Oasis Skin Care

Circle your responses (Please print)

Name: _____ Phone: _____ Cell: _____
Address:_____ City: _____ State: _____ Zip: _____
Email: _____ Date of Birth: _____ Age: ____
____*** **Please check here to receive our special of the month by email*****

Your response to the following questions will assist us in evaluating your skin and formulating a custom skin care regimen for you.

Have you ever seen a physician for your skin? Yes/No
Do you wear contact lenses? Yes/No
Please list all health issues _____
Please list all infectious diseases _____
Do you wax or use depilatories on your face? Yes/No Date last used: _____
Do you get cold sores? Yes/No Medication: _____
Do you use Cleanser Yes/No Type: _____
Toner Yes/No Type: _____
Day Treatment Yes/No Type: _____
Moisturizer Yes/No Type: _____
Sun Screen Yes/No Type: _____
Night Treatment Yes/No Type: _____
Eye Cream Yes/No Type: _____
What oral medications do you currently use? _____
Sedatives (Valium/Xanax) - Yes/No Antibiotics - Yes/No Hormones/Birth Control – Yes/No Accutane – Yes/No
Diuretics (Water Pills) – Yes/No Other Medications - _____

Hypersensitivity and Fragility:

Do you have skin allergies? Yes/No Allergies to any of the following (circle): Cosmetics/Latex/Aspirin/Papaya/Pineapple
Do you have any known allergies to anything? Yes/No
If YES, please list all allergies (including medications, aspirin, food, etc)
_____
Do you "flush" or "appear reddened" when eating spicy foods, drinking alcohol, getting angry, while in the sun, etc? Yes/No

Hormones:

Do you have regular periods? Yes/No Are you going through Menopause? Yes/No
Are you pregnant or lactating? Yes/No During pregnancy did you ever get hyperpigmentation or masking? Yes/No

Diet and Exercise:

Do you consume caffeine? Yes/No How much/often: _____
Do you smoke? Yes/No How much/often: _____
Do you exercise? Yes/No Times per week: _____
Do you consume alcohol? Yes/No Glasses per week:_____
How many hours do you sleep at night? _____

Skin Evaluation: Please circle all that apply to you

How do you tan? Always Burn Usually Burn Burn then Tan Usually Tan Always Tan
Pigmentation: Even Uneven Birthmark Pregnancy Mask
Broken Capillaries: Forehead Nose Cheek Chin Entire Face
Do you have a history of acne or breakouts? Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars
How often do you experience blackheads or facial blemishes? Frequently Occasionally Very Rarely
Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely
After cleansing your face in the AM, how soon do you notice an oily shine? Before Noon Noon to 3pm After 3pm Not at All
Your skin type is: Normal Combination Dry Oily Acne/Acne Prone Sensitive
Have you had skin cancer? Yes/No Anatomical Location: _____
How do you want to improve your skin? Texture Uneven Color Wrinkles Other: _____
What specific areas do you want to treat? Face Neck Chest Back Hands Forearms
Have you ever undergone facial cosmetic/reconstructive surgery? Yes/No When: _____ Where: _____
Who may we thank for referring you? _____

Regarding Herpes Simplex Types I & II: Anyone with a history of Herpes Simplex I or II has been advised that any facial, waxing, peel, dermaplaning or microdermabrasion service may cause an outbreak to resurface. _____ (Initial)

I certify that I have answered the questions to the best of my ability. I will notify Dr Blount's office immediately of any pertinent change in my medical condition.

Signature: _____ Date: _____