

# Ocean Med Spa Facial Intake Form

915 SE Ocean Blvd #5  
Stuart, Florida 34994

Name: \_\_\_\_\_ Date of Birth: / \_\_\_\_ / \_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Ph: \_\_\_\_\_

## Your Skin

**Yes No** Do you have allergies? If yes, which ones: \_\_\_\_\_

**Yes No** Have you had a chemical peel in the last 6 months?

**Yes No** Do you experience skin breakouts?

**Yes No** Do you experience oily shine throughout the day?

**Yes No** Do you ever experience a burning, itching sensation on your skin?

**Yes No** Do you ever experience flakiness and/ or tightness?

**Yes No** Do you use SPF on your face? If so which one: \_\_\_\_\_

**Yes No** Do you sunbathe or use tanning beds?

**Yes No** Do you burn easily in moderate sunlight?

**Yes No** Do you blush easily when nervous?

**Yes No** Do you have a tendency to redness?

**Yes No** Do you suffer from sinus problems?

**Yes No** Have you ever experienced a reaction to any skin care products? If so which ones: \_\_\_\_\_

**Yes No** Within the last year have you been under the care of a dermatologist or other physicians care? If so what for? \_\_\_\_\_

**Yes No** Within the last 2 years have you undergone any surgeries? If yes, please specify: \_\_\_\_\_

**Yes No** Have you had any health problems past or present? If yes, please specify: \_\_\_\_\_

**Yes No** Do you have any special skin problem pertaining to your face or body? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**Yes No** Do you smoke?  
\_\_\_\_\_  
\_\_\_\_\_

**What skin care products are you currently using?**

Soap Cleanser \_\_\_\_\_ Toner \_\_\_\_\_

Exfoliator \_\_\_\_\_ Moisturizer \_\_\_\_\_

Masque \_\_\_\_\_ Eye Products \_\_\_\_\_

Other \_\_\_\_\_

**Yes No** Do you currently use Accutane, Retin A, Renova, Adapalene or any other prescription skin care products? If yes, please list:  
\_\_\_\_\_

**Yes No** Are you currently using any products that contain the following ingredients, please circle all that apply:

**Glycolic Acid, Lactic Acid, Exfoliating Scrubs, Hydroxy Acids, Vitamin A Derivatives**

**Yes No** Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? If yes, how long?  
\_\_\_\_\_

How much water do you consume daily? \_\_\_\_\_

How many alcoholic beverages do you consume weekly? \_\_\_\_\_

What are your skin care goals? \_\_\_\_\_

## **Facial Consent**

If I experience any pain or discomfort during this session, I will immediately inform the esthetician so that the session may be adjusted to my level of comfort. I further understand that esthetics should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that licensed estheticians are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing that is said in the course of the session given should be construed as such. Because esthetics should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Fier Eye Care and Surgery Center and the Esthetician updated to any changes in my medical profile and understand that there shall be no liability on Fier Eye Care and Surgery Center and the Esthetician's part should I fail to do so.

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Client Signature

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Date