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.

_____ _____

Client Signature Date