NSF#

Confidential Client Health History Form—continued

8) Do you smoke? ❍ No ❍ Yes

9) Do you follow a restricted diet? ❍ No ❍ Yes, specify: _____

10) Do you follow a regular exercise program? ❍ No ❍ Yes

11) What is your stress level? High ❑ Medium ❑ Low ❑

List any medications you take regularly: _____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

_____

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? ❍ No ❍ Yes, describe: _____

13) Have you used any of these products in the last 3 months? ❍ No ❍ Yes

14) Have you used an acne medication? ❍ No ❍ Yes, when? _____ Which drug? _____

15) Do you form thick or raised scars from cuts or burns? ❍ No ❍ Yes

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❍ No ❍ Yes, describe: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

17) Do you experience any problems sleeping? ❍ No ❍ Yes

18) How many hours do you typically sleep each night? _____

19) Do you wear contact lenses? ❍ No ❍ Yes

20) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ❍ No ❍ Yes

21) How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___Regularly

22) Do you have any metal implants or wear a pacemaker? ❍ No ❍ Yes

23) Have you ever experienced claustrophobia? ❍ No ❍ Yes

24) Do you suffer from sinus problems? ❍ No ❍ Yes

25) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

26) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____