VIVID MD Skin Care

CONSULTATION CHART

Name ____

Address ____________________ City______________ State _____ Zip Code ________

Telephone ______________ Email ____________________ Birthdate __________

Date of Consultation ____________ How did you hear of us? ______________________

Occupation ________________________ M ☐ F ☐

CLIENT HISTORY - *WE CAN ACHIEVE YOUR GOALS ONLY IF YOU ARE HONEST WITH YOUR ANSWERS*

1. Are you now or within the last year under a physician's care? Dermatologist? Plastic Surgeon?
☐ Yes ☐ No
If yes, specify ______________________

2. Have you undergone any surgery in the last nine months?
☐ Yes ☐ No
If yes, specify ______________________

3. Have you had any of these health problems past or present?
☐ Cancer ☐ Hormone Imbalance
☐ Diabetes ☐ Hysterectomy
☐ Epilepsy ☐ Thyroid
☐ Heart Problem ☐ Varicose Veins
☐ HIV or AIDS ☐ Facial Warts
☐ STDs ☐ Drug Addiction
☐ Hepatitis ☐ Cold Sores

4. List any medications and vitamins that you take regularly:
____
____
condition(s): ______________________

5. Do you have permanent make-up?
☐ Yes ☐ No
If yes, where ______________________

6. Do you have any special skin problems or concerns pertaining to your face?
☐ Yes ☐ No
If yes, specify ______________________

7. Do you have any special concerns pertaining to your body?
☐ Yes ☐ No
If yes, specify ______________________

8. Do you:

smoke	☐ Yes	☐ No
use Retin-A	☐ Yes	☐ No
ever use Accutane	☐ Yes	☐ No
follow a restricted diet	☐ Yes	☐ No
exercise regularly	☐ Yes	☐ No
have regular sleep patterns	☐ Yes	☐ No
have chemically lightened hair	☐ Yes	☐ No
wear contact lenses	☐ Yes	☐ No

9. What types of skin care products are you currently using daily?
☐ soap/cleanser ☐ toner ☐ serums
☐ scrub ☐ moisturizer ☐ sunblock
☐ acne spot treatment ☐ skin bleacher
Indicate WEEKLY use of:
☐ scrub/peel/microdermabrasion cream
☐ masque: ______________________
☐ other ______________________

10. Have you ever had a facial treatment before?
☐ Yes ☐ No
If yes, specify ______________________

11. Have you ever had plastic surgery?
☐ Yes ☐ No
If yes, specify ______________________

12. Have you ever had
☐ Chemical Peel ☐ Microdermabrasion
☐ Botox ☐ IPL (Photo Facial)
☐ Laser Hair Removal ☐ Laser Resurfacing
☐ Facial Filler (e.g. Restaylane/Collagen)

FEMALE CLIENTS ONLY

1. Are you taking oral contraception?
☐ Yes ☐ No

2. Are you or now trying to become pregnant?
☐ Yes ☐ No ☐ Breast feeding?

MALE CLIENTS ONLY

1. What is your current shaving system?
☐ Wet ☐ Electric

2. Do you ever experience irritation from shaving?
☐ Yes ☐ No

3. Do you experience ingrown hairs?
☐ Yes ☐ No

4. Do you wish you could get a closer shave?
☐ Yes ☐ No

OIL SECRETION

1. Do you experience breakthrough oily shine during the day?
☐ Yes ☐ No

2. Do you experience skin break-outs?
☐ Yes ☐ No ☐ Occasionally

MOISTURE HYDRATION

1. How many glasses of plain water do you consume daily?
☐ None ☐ 1-3 ☐ 4-7 ☐ 8 or more

2. How many alcoholic beverages do you consume weekly?
☐ None ☐ 1-3 ☐ 4 or more

3. Do you ever experience any of the following conditions on your skin?
☐ Flakiness ☐ Tightness ☐ Obvious dryness

4. Do you use a sunscreen/sunblock?
☐ Always ☐ Sometimes ☐ Never
☐ Only when I go outside
What SPF do you use? _________

ESTHETICIAN COMMENTS

____
____
____
____
____
____
____
____

CAPILLARY ACTIVITY

1. Do you burn easily in moderate sunlight?
☐ Yes ☐ No

2. Do you blush easily when nervous?
☐ Yes ☐ No

3. When/if drinking alcohol, do your cheeks turn red?
☐ Yes ☐ No
Spicy food?
☐ Yes ☐ No

4. When/if eating salt, do you experience puffy skin (possibly around the eye area)?
☐ Yes ☐ No

5. Do you have a natural tendency to redness?
☐ Yes ☐ No

6. Have you ever suffered any sinus problems?
☐ Yes ☐ No

NERVE ACTIVITY

1. How many cups of caffeine-type beverages (coffee, tea, soft drinks) do you drink daily?
☐ None ☐ 1-3 ☐ 4 or more

2. What level do you consider your pain threshold to be?
☐ Low ☐ Medium ☐ High

3. Have you ever experienced any claustrophobia?
☐ Yes ☐ No

4. Have you ever experienced a reaction to any of the following?
☐ Cosmetics ☐ Pollen ☐ Aspirin
☐ Medicine ☐ Food ☐ Glycolic Acid
☐ Iodine ☐ Shellfish ☐ Hydroquinone
☐ Fragrance ☐ Milk ☐ Sunscreens
☐ Sulfa ☐ AHAs ☐ Animals
☐ Sulfur
☐ Other: ______________________________

QUESTIONS TO UPDATE EACH VISIT

1. Are you currently having or due for your menstrual period?
☐ Yes ☐ No

2. Have you started any new medications?
☐ Yes ☐ No
If yes, specify ______________________________

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment

Client
Signature: ______________________________

(OFFICE USE ONLY)

RECOMMENDED REGIMEN			
AM	PM	Weekly	VMD

OTHER RECOMMENDED TREATMENTS

TODAYS DATE

VIVID MD
Skin Care