

# MICRODERMABRASION CONSULTATION FORM

## GENERAL INFORMATION

Full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

What is your gender?     Male     Female     Non-binary     Other

Are you 18 years of age or over?     Yes     No

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

Would you like to be added to our email list for specials and discounts?     Yes     No

## MEDICAL INFORMATION

Please describe any specific skin concerns or areas you would like to target during the microdermabrasion treatment: \_\_\_\_\_

Are you pregnant?     Yes     No

Do you have any recent sunburn?     Yes     No

Do you have any active cold sores or herpes?     Yes     No

Have you had any chemical peels or facial laser treatments? (last 2 weeks)     Yes     No

Do you have any skin cancer history?     Yes     No

Have you used Accutane? (past 6 months)     Yes     No

Have you used or are on any blood thinners?     Yes     No

Other medical conditions: \_\_\_\_\_

## SKIN HISTORY

History of skin conditions:

Previous facial treatments:

Allergies or sensitivities:

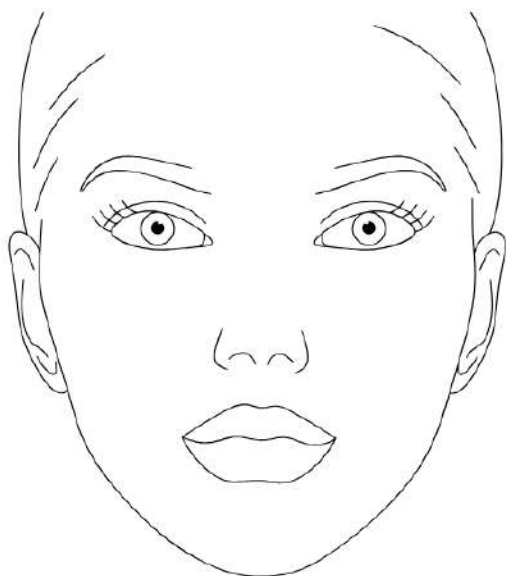
Current skincare routine:

Medications or supplements:

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(continued)

### SKIN DISORDERS/CONDITIONS



**NOTES**

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Acne	A	Comedones	C	Thin	T
Asphyxiated	As	Milia	Mi	Warts	W
Breakout activity	Br	Mole	Mo	Deep lines	DL
Broken capillaries	BC	Sensitivity/redness	S/R	Hyperpigmentation	H+
Discoloration	D	Rosacea	R	Hypopigmentation	H-
Dilated capillaries	DC	Scars	Sc	Photo aging	A
Keloid	K	Skin tags	ST	Psoriasis	Ps
Open pores	OP	Spider veins	SV	Pustules	Pu
Oily	O	Sunburn	Su	Papules	Pa