



How much water do you consume per day? \_\_\_\_\_

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

- |                                                |                                            |                                                       |
|------------------------------------------------|--------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Cleaner _____         | <input type="checkbox"/> Soap _____        | <input type="checkbox"/> Toner _____                  |
| <input type="checkbox"/> Moisturizer _____     | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____                   |
| <input type="checkbox"/> Eye Cream _____       | <input type="checkbox"/> Astringent _____  | <input type="checkbox"/> Glycolic Wash/Cleanser _____ |
| <input type="checkbox"/> Scrub _____           | <input type="checkbox"/> Sunscreen _____   | <input type="checkbox"/> Salicylic Wash/Cleaser _____ |
| <input type="checkbox"/> Vitamin A Cream _____ |                                            |                                                       |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? Please list: \_\_\_\_\_

Please check any health problems, past or present?

- |                                                                 |                                            |                                         |                                              |
|-----------------------------------------------------------------|--------------------------------------------|-----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Liver disease     | <input type="checkbox"/> Skin cancer    | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Cystic acne    | <input type="checkbox"/> Hormonal problems   |
| <input type="checkbox"/> Thyroid                                | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Collagen (lupus, sarcoid, scleroderma) | <input type="checkbox"/> Vasovagal syncope | <input type="checkbox"/> Other _____    |                                              |

Do you have any of the following chronic skin disorders?

- |                                         |                                     |                                       |                                                  |
|-----------------------------------------|-------------------------------------|---------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Keloid scarring         |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Sun blisters | <input type="checkbox"/> Herpes simplex/blisters |

Have you ever undergone any of the following treatments?

- |                                    |                                           |                                   |                                            |
|------------------------------------|-------------------------------------------|-----------------------------------|--------------------------------------------|
| <input type="checkbox"/> Acid peel | <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Accutane | <input type="checkbox"/> Macrodermabrasion |
|------------------------------------|-------------------------------------------|-----------------------------------|--------------------------------------------|

Please explain: \_\_\_\_\_

Are you currently removing hair by any of the following methods?

- |                                             |                                   |                                             |                                       |
|---------------------------------------------|-----------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Waxing             | <input type="checkbox"/> Tweezing | <input type="checkbox"/> Nair type products | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Laser hair removal |                                   |                                             |                                       |