



P.O. box 352
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877/493/5130

Skin Care Analysis

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone () _____ Business Phone () _____

Date of Birth _____

Please check any health conditions which you have had or are now experiencing:

- Hypoglycemia
- Heart Problems
- Hysterectomy
- Hormonal Problems
- Other
- High/Low Blood Pressure
- Cancer
- Thyroid (Over/Under)
- Sugar Diabetes
- Hepatitis
- Alcoholism
- Thyroid (Over/Under)
- Metabolic Disorders

Are you pregnant? Yes No

What is your Ethnic Background?

Please list all medications that you take regularly.
Include hormones, vitamins, etc.

Describe a typical day's diet and salt consumption.

Types and quantities of fluids consumed daily-

Water _____ Coffee _____ Teas _____ Other _____
Teas _____ Juices _____ Colas _____

Do you smoke? Yes No
How much? _____

Have you ever had an allergic reaction to products you have applied to your skin?

Yes No

What product or ingredients? _____

Do you have allergies? _____

What type? _____

Have you ever applied pharmaceutical or prescription grade products to your skin?

What products or ingredients? _____

Any side effects? _____

Have you ever undergone treatment from a dermatologist? Yes No

When? _____

For what type of condition? _____

Any negative side effects? _____

What type of climate do you live in?

How much sleep do you get per night?

How much exercise do you get per day?

Are you currently or periodically under a lot of stress?

What is your specific concern with your skin?

What is your level of commitment to a skin care regimen?

Do you consider yourself to have Dry, Normal or Oily Skin? _____

When looking in the mirror, can you see your pores? Yes No

How often do you cleanse?

What do you use to cleanse?

After cleansing does your face feel taught and dry? Yes No

When you wake up in the morning does your face feel taught, dry, perfect or oily?

Do you prefer the feel of a Milk or Gel based cleanser? _____

Does your skin have a rough scaly appearance and feel? Yes No
Where?

Do you have irritation and/or dry patches? Yes No
Where?

Does your skin tone have brown spots and or blotches? Yes No
Where?

Does your skin tone have a reddish appearance? Yes No
Where?

Can you visible see red veins running through your cheek area? Yes No

Do you have any scarring? Yes No
From what?

Do you have fine wrinkles? Yes No
Where?

Do you have deep lines? Yes No
Where?

Do you have acne? Yes No
Small bumps? Yes No
Small pustules? Yes No
Large pustules? Yes No

Do you use sunblock daily? Yes No

Do you have visible sun damage? Yes No
What does it look like to you?

How does your skin react to sun exposure?

How much sun exposure have you incurred in your lifetime?

Do you use Retin A? Yes No
For what type of condition?

Are you currently or have you ever used Accutane? Yes No



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