Be Blessed®
SKINCARE

Name _____Age_____ DOB _____

Address _____

Contact Phone Number_____

Email _____

Prescribed, Over the Counter and Recreational Drug / Medications (past and present use):

Medication	When	How Long	Medication	When	How Long
Antibiotics			Testosterone		
Accutane			Progesterone		
Benzoyl Peroxide			Disufuram		
Clindamycin Topical			Cyclosporin		
Adapalene			Dilantin		

Retin A Cream or Gel			Lithium		
Tazorac			Thyroid Medication		
Differin			Quinine		
Azelex			Isoniazid		
Sulfur			Immuran		
Clindamycin Oral			Danzol		
Androstendione			Gonadotrophin		
Cortisone			Steroids		
Minocycline			Recreational Drugs		
Copaxone			Antidepressants		

Products now using – please write product name

Cleanser_____

Toner_____

Serums_____

Moisturizers_____

SPF_____

Mask_____

Foundation_____

Blush_____

Exfoliants_____

Acne
Medications_____

Have you ever had any allergic reactions to any of the above products or anything you have ever put on your face?
_____

If yes, what product: _____ Describe:
_____

Check if you are allergic to: _____ sulfur _____ aspirin _____ latex _____Do you smoke?
_____

Do you feel like your skin is: oily_____ dry_____ sensitive_____combination_____(check all that apply)

Lifestyle Considerations

At what age did your acne start? _____

Do you use fabric softener or fabric softener sheets in the dryer? _____

Do you pick at your skin? _____

Do you work around chemicals, tars, oils or inks? _____

Are you currently under a lot of stress? _____

Do you regularly eat or ingest: ____ kelp ____ seaweed ____ sushi ____ salt ____ fast foods ____ milk / cheese

Women only: Are you on birth control pills? If yes, name of pill:
_____

Are you taking Depo Provera shots? _____ Are you pregnant or nursing? _____

What are your skin care concerns:

____ Blackheads	____ Dehydrated Skin	____ Dry Flaky Skin	____ Oily
____ Whiteheads	____ Dark Spots	____ Sensitive Skin	____ Normal
____ Pimples/Pustules	____ Age Spots	____ Razor Bumps	____ Dry
____ Cysts	____ Broken Capillaries	____ Shaving Irritation	____ Oily/Dry
____ Oily Skin	____ Fine Lines/Wrinkles	____ Acne Rosacea	____ Sensitive

What else have you done for your skin:

Service	**When**	**Service**	**When**
____ Glycolic Acid Peels		____ Laser Hair Removal	
____ Microdermabrasion		____ Facial Waxing	
____ Chemical Peels		____ Electrolysis	
____ Skin Cancer Removal		Anything else?	
____ Plastic Surgery			

Medical History: check any condition you may have had in the past two years

____ Diabetes	____ Hepatitis	____ Hemophilia

____ Thyroid Problems	____ HIV + or AIDS	____ Thrombosis / Blood Clot /Stroke
____ Eczema	____ Staph Infection or MRSA	____ Metal pins or brackets in body
____ Psoriasis	____ Hormone Problems	____ Pacemaker
____ Pregnancy	____ Herpes Simplex/Cold Sores	____ Hysterectomy / ovaries removed
____ Nursing	____ High Blood Pressure	____ PCOS
____ Cancer	____ Anemia	____ Lupus

Are you under a Dermatologist's Care? _____ If so, name of Dr_____

What kind of work do you do?

_____

How did you hear about us?

_____

Describe your struggle with acne in your own words:_____

_____

_____

_____

_____

What results would you like to obtain with your skin?

_____

_____