

MICRODERMABRASION HEALTH QUESTIONNAIRE

Name: _____ Age: _____
Home Phone: _____ Work Phone: _____

Are you currently under the care of a physician for a specific condition? Yes No
If yes, list reason(s)

List all current medication: (Include ointments and creams prescribed by a physician.)

Circle all that apply:

- | | | |
|-------------------------|------------------------------|-------------|
| Blood Thinners | Viral Lesions-Herpes Simplex | Eczema |
| Uncontrolled Diabetes | Vascular Lesions | Active Acne |
| Sinus Infections | Pregnant/Nursing | Skin Cancer |
| Facial/Oral Surgery | Auto Immune Disease | Hepatitis |
| High/Low Blood Pressure | Keloid Scars | Dermatitis |

Please explain any items circled above if indicated:

Circle products if you are currently using them on areas to be treated.

Retin-A Salicylic Acid Alpha or Beta Hydroxy Products Accutane

Others: _____

Please list any previous facial treatments and date. (i.e. chemical peel, microdermabrasion with crystals, laser resurfacing).

What do you hope to achieve from microdermabrasion?

Signature: _____ Date: _____
Physician : _____ Date: _____