SOUND SHORE AYURVEDA, LLC

Confidential Skin Health Survey

Name ______________________________ Date ________________

Address ______________________________ Email Address ________________

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Phone Number/ Home ______________ Phone Number/Cellular ______________

Dermatologist/Physician ________________ Phone ________________

Emergency Contact/ Name ________________ Phone ________________

Referred by Friend Web Search Other ________________

Please answer all questions

Is this your first facial? Yes: No:

What special areas of concern do you have? ______________________________

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Are you presently under a physician's care for any current skin condition or other problem?
Yes: No: (If Yes, explain) ______________________________

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Are you pregnant? Yes (# of months): _____ No: Do you smoke? Yes: No:

Are you taking birth control? Yes (type): ______________________ No:

Hormone replacement? Yes: No: Do you wear contact lenses? Yes: No:

Do you often experience stress? Yes: No:

Have you ever had skin cancer? Yes: No:

Are you using now (or in the past): Differin: Renova: Retain-A: Tazarac:
Glycolic or Alphahydroxy Acids: if so how long? __________

Are you now or ever using Accutane? Yes: No: If so how long? __________

Do you have acne? Yes: No:
Experience frequent blemishes? Yes: No: If so how frequently? __________

Do you have any allergies to essential oils, cosmetics or foods? Yes: No:
Please list: ______________________________

Are you presently taking any medications oral or topical? Yes: No:
Please list: ______________________________

What products do you use presently? (List brand or types...)
Soap: Cleansing: Milk: Toner:

Scrub: Mask: Creams:

Sunscreen: Other:

Sound Shore Ayurveda, LLC

Please check Yes or No to the following questions. If answering yes, please list any medications which you are currently taking.

Do you have any of the following health concerns?

Asthma ☐Yes ☐No Medications ____________________

Cardiac Problems ☐Yes ☐No Medications ____________________

Eczema ☐Yes ☐No Medications ____________________

Epilepsy ☐Yes ☐No Medications ____________________

Fever Blisters ☐Yes ☐No Medications ____________________

Headaches ☐Yes ☐No Medications ____________________

Hepatitis ☐Yes ☐No Medications ____________________

Herpes ☐Yes ☐No Medications ____________________

High Blood Pressure ☐Yes ☐No Medications ____________________

Immune Disorders ☐Yes ☐No Medications ____________________

Lupus ☐Yes ☐No Medications ____________________

Metal Bones, Pins, Plates ☐Yes ☐No Describe ____________________

Pacemaker ☐Yes ☐No Describe ____________________

Sinus Problems ☐Yes ☐No Medications ____________________

Skin Problems ☐Yes ☐No Medications ____________________

Skin Diseases ☐Yes ☐No Medications ____________________

Urinary or Kidney Problems ☐Yes ☐No Medications ____________________

Are there any other concerns that you wish your Esthetician to know about concerning your skin care in our facility? ____________________

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I understand that the services offered are not a substitute for medical care and any information provided by the therapists is for education purposes only and not diagnostic in nature. I further understand that the information herein is to aid the therapist in providing better services according to my individual needs and is completely confidential.

I recognize and acknowledge that Sound Shore Ayurveda, LLC has a 24 hour cancellation policy, and that I will be billed for my appointment in full if I cancel my appointment with less than 24 hours notice.

____________________ Signature

____________________ Date