Carol Billingsley
ADVANCED SKIN CARE

Tennessee & Georgia
Board Certified Master Aesthetician

2051 Hamill Road, Suite 301
Hixson, TN 37343

History & Intake

Date:_____/_____/_____ Birthday:_____/_____/_____

Last name:_____ First name:_____ Middle:_____

Address:_____ Home Phone:(_____)_____ - _____

City:_____ State:_____ Zip:_____ Work Phone:(_____)_____ - _____

Date of first visit:_____/_____/_____ Skin Care Counselor:_____ Physician:_____

Have you ever received treatment from a dermatologist? (circle one) YES NO

If YES, for what condition?_____

Date of last Melanoma check? _____/_____/_____ Was test negative? (circle one) YES NO

Do you have any skin lesions, moles or lesions?_____

Describe your skin pigmentation: (circle one) EVEN UNEVEN Do you have any birthmarks? (circle one) YES NO

Location of Birthmarks:_____

Do you have broken capillaries? (circle one) YES NO (mark all that apply) __Nose __Cheek __Chin __Forehead __Legs

Do you have facial wrinkles? (circle one) YES NO

(mark all that apply) ___Deep Furrows ___Wrinkles ___Fine Lines ___Crow's Feet ___Flown Lines ___Marionette Lines ___Lip

How do you tan? (mark all that apply) ___Burn ___Usually Burn ___Burn, then Tan ___Tan

Do you now, or have you ever, Sunbathed? (circle one) YES NO

What percentage of your time do you spend in the sun? _____Spring/Summer _____Fall/Winter

What sunscreen products and SPF's do you use?_____

List your skincare products: (cleansers, soaps, toners, lotions, etc.):_____

Are you currently pregnant or breast feeding? (circle one) YES NO Are you diabetic? (circle one) YES NO

Are you taking any of the following? ___Vitamin E ___Fish Oil ___Omega 3 ___DHEA ___Hormones

What Topical Medications are you currently using? Acne Medications:_____

Renova:_____ Retin-A:_____

Vitamin C Products:_____ Glycolic Acid Products:_____

What would you like to see improved about our skin?_____

What specific areas of the body are you interested in having treated? __Face __Skin __Breast __Legs __Abdomen ___Eyes

__Forehead __Buttock __Feet __Neck __Lips __Torso __Thighs __ Back Other:_____

Do you have a history of Acne or periodic breakouts? (circle one) YES NO

(mark all that apply) ___Pimples ___Whiteheads ___Blackheads ___Enlarged Pores ___Flakiness ___Acne Scars

Skin Type: (Please Mark Only ONE) ___Normal ___Dry ___Oily ___Combination ___Sensitive

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