

PATIENT/CLIENT INFORMATION

DATE _____
 NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 HOME PHONE _____
 WORK PHONE _____
 CELL _____
 EMAIL _____
 OCCUPATION _____
 REFERRED BY _____

MEDICAL INFORMATION

DATE OF BIRTH _____ AGE _____ FAMILY PHYSICIAN _____
 DO YOU SMOKE? _____ HOW OFTEN? _____ LIVING WITH A SMOKER? _____
 HAVE YOU BEEN TREATED FOR: (PLEASE CHECK)
 ACNE DEPRESSION SKIN DISEASE HIGH BLOOD PRESSURE
 COLDSORES DIABETES CANCER
 LIST OF ALL ALLERGIES/ALLERGIC _____
 LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING _____
 ARE YOU PREGNANT? _____ TRYING TO GET PREGNANT? _____ HORMONE THERAPY? _____
 ARE YOU PRONE TO COLD SORES? _____

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
 CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ DO YOU TAKE SUPPLEMENTS/VITAMINS? _____
 DO YOU EXERCISE? _____ IF SO, HOW OFTEN: _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____

WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE CHECK ONE):
 ALWAYS BURN (I) USUALLY BURN (II) SOMETIMES BURN (III) RARELY BURN (IV) VERY RARELY BURN (V) NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:
 DERMATOLOGIST PLASTIC SURGEON ESTHETICIAN WOULD YOU BE INTERESTED IN COSMETIC SURGERY? _____

IF YES, WHAT PROCEDURE? _____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY)

SUN SPOTS SKIN LAXITY DRY / ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING? _____

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? _____ IF NOT, WHY? _____

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CHECK ONLY ONE):

NORMAL DRY/DEHYDRATED OILY ACNE/ACNE PRONE ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

____ REDUCTION OF FINE LINES	____ ACNE SCARS DIMINISHED
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE	____ REDUCTION OF REDNESS
____ REDUCTION OF OIL/ACNE	



1 RIGHT FOREHEAD 5 LEFT CHEEK
 2 LEFT FOREHEAD 6 RIGHT CHEEK
 3 LEFT EYE AREA 7 CHIN
 4 RIGHT EYE AREA 8 NECK

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

PROFESSIONAL TREATMENT RECOMMENDATION

ORMEDIC LIFT LIGHTENING LIFT ACNE LIFT IMAGE PERFECTION LIFT
 SIGNATURE LIFT WRINKLE LIFT ACNE ADVANCED LIFT TCA LIFT

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.
 THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: _____ DATE: _____

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