IMAGE
SKINCARE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

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

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
◯ COLD SORES ◯ DIABETES ◯ CANCER
LIST OF ALL ALLERGIES _____
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

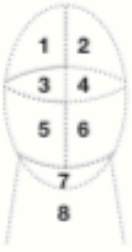
CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10
HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ DO YOU TAKE SUPPLEMENTS/VITAMINS? _____
DO YOU EXERCISE? _____ IF SO, HOW OFTEN: _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____
WHEN YOU GO OUT INTO THE SUN, DO YOU (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 ◯ AESTHETICIAN ◯ 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
____ REDUCTION OF BROWN SPOTS/SUN DAMAGE
____ REDUCTION OF OIL/ACNE
____ ACNE SCARS DIMINISHED
____ REDUCTION OF REDNESS



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

TREATMENT PLAN

PROFESSIONAL TREATMENT RECOMMENDATION

◯ I PEEL ormedic lift™
◯ I PEEL the signature facelift®
◯ I PEEL lightening lift®
◯ I PEEL lightening lift® *FORTE*
◯ I PEEL wrinkle lift®
◯ I PEEL wrinkle lift® *FORTE*
◯ I PEEL acne lift®
◯ I PEEL beta lift™
◯ I PEEL perfection lift™
◯ I PEEL perfection lift™ *FORTE*
◯ O² lift®
◯ IMAGE facial

Thank you for completing this confidential questionnaire. This information will allow your professional skincare specialist to provide the optimum IMAGE Skincare products and services.

SIGNATURE: _____ **DATE:** _____

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