

CLIENTS NAME: _____

CLIENTS SIGNATURE: _____

DATE: _____

PERSONAL DETAILS

Physical address: _____

Postal address: _____

Date of birth: _____

Occupation: _____

Tel (H): _____

Tel (W): _____

Fax: _____

Mobile: _____

E-mail: _____

Referred by: _____

Tel: _____

SKIN DESCRIPTION

Skin quality:

- Dry skin
- Normal skin
- Oily skin
- Oily T-panel

Skin sensitivity:

- Normal - not sensitive
- Sensitive
- Very sensitive

Skin breakouts:

- Acne
- Acne rosacea
- Occasional pimples
- Breakouts from menstrual periods

Skin type:

- Type I - Always burn, never tan
- Type II - Usually burn, tan with difficulty
- Type III - Sometimes mild burn, tan about average
- Type IV - Rarely burn, tan with ease
- Type V - Brown skinned people, don't burn but tan
- Type VI - Black skinned people, never burn but tan

HISTORY OF YOUR SKIN

Are you, or have you been treated for acne with any of the following?

- Topical vitamin A e.g. Retin A
- Vitamin A variants e.g. Differin Gel
- Benzoyl Peroxide
- Azelaic Acid
- Salicylic Acid
- Alpha Hydroxy Acids
- Oral antibiotics
- Isotretinoin e.g. Roaccutane
- Other (please specify): _____

ARE YOU PRONE TO ANY OF THE FOLLOWING?

- Keloid scarring**
- Atopy or Eczema**
- If you are, is it localised or extensive? _____

Are you, or have you been treated with any of the following?

- Topical corticosteroids
- Oral corticosteroids
- Other (please specify): _____
- State affected areas: _____

Psoriasis

- If you are, is it localised or extensive?

Are you, or have you been treated with any of the following?

- Vitamin A products
- Vitamin D products
- Corticosteroids
- Other (please specify): _____
- State affected areas: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Facial surgical procedures
- Laser treatments
- Laser hair removal
- Dermabrasions
- Moles or sun spots removed
- Waxing
- Chemical peelings (please specify): _____
- Other skin care treatments (please specify): _____

GENERAL HEALTH

Are you, or do you have any of the following?

- On a diet
- Pregnant
- Diabetic
- Porphyria
- Facial metal implants / Excess fillings
- Pacemaker / Cardiac irregularities
- Untreated sinusitis

Are you taking any of the following?

- HRT (Hormone Replacement Therapy)
- Contraceptive pill
- Medication (please specify): _____

Vitamin supplements (please specify): _____

Do you suffer from any known allergies, e.g. Aspirin? (please specify): _____

HISTORY OF SUN EXPOSURE

- Do you use a sunscreen daily?
- Do you, or have you done any of the following?
- Sunbathing
- Using sunbeds
- Outdoor sports
- Gardening

HISTORY OF PRODUCTS USED

Are you using Environ® skin care products? (Please specify which products and duration of use): _____

What skin care products have you used before Environ®? _____

What other skin care products are you currently using? _____



ENVIRON®