Studio Booseh
PERMANENT BEAUTY

Name _____ E-Mail Address_____Date_____

Address _____ City _____ State _____
Zipcode_____

Home Phone (___) _____Work Phone (___) _____ Cell (___) _____

MEDICAL INFORMATION

Date of Birth _____ Age _____ Family Physician_____

Do you smoke? YES/NO How often? _____ Do you live with a smoker? YES/NO

Have you been treated for: (circle all that apply)?

Acne Depression Skin Disease High Blood Pressure Cold Sores Diabetes Cancer

List all allergies/allergic reactions to any product:_____

List all medications that you are currently taking:_____

PERSONAL INFORMATION

Are you pregnant? YES/NO. Trying to get pregnant? YES/NO. Are you on hormone therapy? YES/NO. Do you get cold sores? YES/NO.

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

Do you exercise? YES /NO. If so, how often: _____ When was your last sunburn?
_____

Do you use tanning beds? YES/NO. If yes, please explain why _____

Have you used Retin A? YES/NO. When you go out into the sun, do you: (circle 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 of a: Dermatologist _____ Plastic Surgeon _____ Esthetician _____

What skin line are you currently using: _____ Makeup brand:_____

Do you wear an environmental protection cream daily? _____ If not, why_____

Circle how you feel about the overall quality of your skin: 1 (bad) 2 3 4 5 6 7 8 9 10 (Fantastic)

Your skin type is (circle ONLY one): Normal Dry / Dehydrated Oily Acne / Acne Prone / Rosacea
In order of importance, make a wish list of what you would like to see improved in your skin in the next 30 days

____ Reduction of fine lines
____ Reduction of oil/acne
____ Reduction of Redness
____ Hair Removal Waxing
____ Reduction of brown spots/Sun Damage
____ Acne scars diminish
____ Reduce Poor Size

Signature: _____ Date: _____