



17. Do you get sores/blisters (Herpes Zoster/Shingles)?  Yes  No

18. What medications/hormone replacement/vitamins do you presently take?

19. Have you ever used  Accutane  Retin-A  Renova  Topical Antibiotics  
 Differin  Tarazac  Alpha hydroxy acids?  Hydroquinone (Lightener)

If yes, when and for how long? \_\_\_\_\_

20. Any personal or family history of skin cancer?  Yes  No

Provide detail \_\_\_\_\_

21. How would you describe your overall health?  Excellent  Good  Fair  Poor

22. Have you had any of the following past or present?

Acne	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Arthritis or Bursitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Blood pressure	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Breast implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cholesterol	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Claustrophobic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diarrhea/constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where _____
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How Often _____
Heart disease/conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What _____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Menopausal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Metal implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pace maker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Serious injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What _____
Sleep problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

23. Have you ever had a reaction to  Cosmetics  Metals  Medications  Food  Fragrance  
 Airborne particles  Aspirin Other \_\_\_\_\_

24. **FOR WOMEN:** Oral contraceptives?  Yes  No  
Are you pregnant or trying to get pregnant?  Yes  No  
Are you taking hormone replacement?  Yes  No  
Do you experience hormone imbalances?  Yes  No  
**FOR MEN:** Do you shave with  Electric Shaver  Razor  
Do you experience skin breakouts?  Yes  No  
Do you have ingrown hair?  Yes  No

#### LIFESTYLE & DIET

1. Is your stress level  High  Medium  Low  
2. Do you normally sleep well?  Yes  No  
3. Do you regularly exercise?  Yes  No  
4. Do you have food intolerances?  Yes  No  
5. Do you follow any special diet?  Yes  No

6. How many glasses of water do you consume daily? \_\_\_\_\_

7. How many glasses caffeinated beverage (coffee, tea, soft drinks) do you consume daily?  1-3  4 or more

8. In our treatment program, it might be necessary to recommend alterations to or additions in your home care regimen; would that be OK with you?  Yes  No

# INFORMED CONSENT RELEASE

I \_\_\_\_\_, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the practitioner will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will consult with my practitioner immediately.

I release and hold harmless Fayces Skin Care and staff from any liability for adverse reactions that may result this treatment.

## POLICIES (Cancellation and "No-Shows")

**You must give us a 24-hour notice if you need to cancel or change your appointment for any reason.** We save a time slot for you. Most of the time, there are several other clients eagerly waiting for a cancellation. A 24-hour notice allows us at least one business day to contact another client in desperate need of your time slot. Please help us reduce our no-show rate (and keep our treatment prices reasonable) by allowing our other clients the opportunity to get their treatments.

For Saturday appointments, you must confirm with us no later than 12 noon on Friday, or your appointment may be given to someone else without further notice to you. Those on a Series of 6 program will forfeit their treatment if they are a "no-show", have broken a Saturday appointment with too short notice, or arrived so late that "working you in" proves unworkable.

**There is a \$30 fee for missed appointments and cancellations with less than 24-hours notice.** If this happens twice, we stop booking appointments for you without advance payment. Thank you for your cooperation.

If you are not satisfied with your service or products, please contact Fayces Skin Care, (310) 313-3223 within 24 hours after your appointment so that the situation can be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information \_\_\_\_\_  
Client signature

Your Initials \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Witness \_\_\_\_\_