Skin by Marywynn Client Questionnaire

Today's Date_____Birthday_____

Name_____

Address_____

City_____State_____Zip_____

Phone_____

E-mail_____

How did you hear about Skin by Marywynn?_____

What is your occupation?_____

Do you have any children? ___yes___no If yes, how many?_____ Age range?_____

Have you ever had a facial? ___yes ___no Do you currently get regular facials? ___yes ___no

If yes, how often are you getting facials?_____

Do you have any allergies (seasonal, food, drugs etc)____yes _____no

If yes, please list _____

Do you have any current medical conditions? _____yes _____no

If yes, please list _____

Are you taking any prescription medications, either topical or internal? _____yes _____no

If yes, please list_____

Do you smoke? _____yes _____no If yes, how many per day _____

Have you had any cosmetic surgery or injections like botox or fillers? If yes, what and when?

_____

Describe your current skin care routine. (Fill in brands)_____

Cleanse?_____Exfoliate?_____Tone?_____

Sunscreen?_____ Moisturize?_____ Eye Cream_____

What are your goals for your skin?

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