SPA HAMBRIK
www.SpaHambrik.com
770.256.6339

The Fountain Oaks Shopping Plaza
Sola Salon Studios
4920 Roswell Road, Studio 123
Atlanta, GA 30342

Name: _____ DOB:_____ Age: _____ Sex: _____
Address: _____
City: _____ ST: ____ Zip: _____ Phone: _____ Email: _____

Please Circle All that Apply: Aids/HIV, Head Aches, Neck Injury, Pacemaker, Diabetes, Clot Disorder, Dermatitis, Diabetic Pump, Other Implanted Medical Devices
Are there any other medical disclosures that we should be aware of? _____

SKIN CARE PROFILE
Are you pregnant or lactating? Yes ___ No ___ **(If so, please consult with your obstetrician. Only the Oxygenating Trio ® or Detox Gel Deep Porte Treatment is appropriate.)**
Do you wear contact lenses? Yes ___ No ___ (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)
Do you have permanent makeup? Yes ___ No ___ (If so, to what areas of the face?) _____
Do you currently use or receive depilatories or waxing? Yes ___ No ___ (discontinue use five days pre- and post-treatment.)
Do you currently have a sunburn/windburn/red face? Yes ___ No ___ Why? _____
Are you in the habit of going to tanning booths? Yes ___ No ___ (if within the past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)
Are you applying any topical medications at this time? Yes ___ No ___ Which one(s)? _____ (High percentages of certain ingredients may increase sensitivity.)
Are you currently using any topical Retinoid prescriptions (tretinoin/ Retin-A®/ Isotretinoin/ Accutane®/ Renova®/ Differin®/ Tazorac®/ Avage®/ EpiDuo/Ziana®)? Yes ___ No ___
What strength? _____ For how long? _____ (Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
Are you currently undergoing isotretinoin therapy (Accutane®)? Yes ___ No ___ For how long? _____ (It is OK to apply ONE layer of Ultra Peel® I, Sensi Peel ®, Ultra Peel® II, Esthetique Peel or Oxy Trio® to skin that has been undergoing isotretinoin therapy (Accutane®)). **Those who are currently undergoing isotretinoin therapy (Accutane®) should be directed to their dispensing physician.**
Have you had a chemical peel or any type of procedure with a medical device? Yes ___ No ___
Within the last 14 days? Yes ___ No ___ What type?
Do you have regular collagen, Botox® or other dermal filler injections? Yes ___ No ___ (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
Have you recently had facial surgery? Yes ___ No ___ Describe: _____ How long ago: _____
Have you recently had laser resurfacing? Yes ___ No ___ When? _____ What type? _____
What type of work do you do? _____ Regular air travel? Yes ___ No ___ How often? _____
Do you participate in vigorous aerobic activity or sports? Yes ___ No ___ What type? _____
Do you smoke or use tobacco? Yes ___ No ___
Do you develop cold sores/fever blisters? Yes ___ No ___ Last breakout? _____
Are you allergic/sensitive to (Check all that apply)? Milk ___ Apples ___ Citrus ___ Grapes ___ Aloe Vera ___ Aspirin ___ Perfumes ___ Latex ___ Hydroquinone ___ Mushrooms ___ Any other allergies? ____
Are you sensitive to alcohol-based products? Yes ___ No ___
Have you ever used any products that caused a bad reaction? Yes ___ No ___ Describe _____
Are you taking any medication at this time? (Antibiotics may increase sensitivity) _____
Skin Tone: Pale/White ___ Light ___ Medium ___ Reddish ___ Freckled ___ Sallow ___ Lt. Olive ___ Med. Olive ___ Dark Olive ___ Lt. Brown ___ Med. Brown ___ Dark Brown ___ Soft Black ___ Black ___
Do you consider your skin: Sensitive ___ Resilient ___ Unsure ___
Describe your skin (Check all that apply): Normal ___ Dry ___ T-Zone/Combination ___ Thick ___ Thin ___ Saggy ___ Firm ___ Oily ___ Acne ___ Comedones/Blackheads ___ Milia ___ Cysts ___ Breakouts ___ Acne-scarred ___ Large Pores ___ Small Pores ___ Florid ___ Rosacea ___ Eczema ___ Freckled ___ Sun-Damaged ___ Melasma ___ Hyperpigmentation ___ Perfume-Stained ___ Hypopigmentation ___ Uneven/Blotchy ___ Mature ___ Wrinkled ___ Patchy Dryness ___ Sallow ___ Psoriasis ___ Dehydrated/Lacking Moisture ___ Asphyxiated ___ Talengiectasia/Broken Skin Capillaries ___
What are the changes you would most like to see in your skin? _____

Patient Signature: _____ Date: _____
Clinician Signature: _____ Date: _____