



The Lux Spa

**SKIN TREATMENT  
PATIENT INFORMATION AND HEALTH HISTORY**

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_

CELL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/ 0000 (no need to give year)

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

HAVE YOU EVER SEEN A DERMATOLOGIST  
FOR YOUR SKIN? Y N

ARE YOU TAKING ACCUTANE? Y N

HAVE YOU EVER TAKEN ACCUTANE? Y N  
WHEN? \_\_\_\_\_

WHAT TOPICAL MEDICATIONS DO YOU USE OR HAVE YOU USED?  
RETIN-A \_\_\_\_\_ GLYCOLIC ACID \_\_\_\_\_ OTHER \_\_\_\_\_

**HYPERSENSITIVITY AND FRAGILITY**

HAVE YOU EVER HAD A SKIN ALLERGY? Y N

COSMETICS \_\_\_\_\_ FABRICS \_\_\_\_\_ ASPIRIN \_\_\_\_\_ OTHER \_\_\_\_\_

**ABILITY TO HEAL**

DOES YOUR SKIN APPEAR FRAGILE OR BURN EASILY? Y N

DO YOU FORM A THICK OR RAISED SCAR FROM ACUT OR BURN? Y N

DO YOU WAX OR USE DEPILATORIES ON YOUR FACE? Y N

DO YOU EVER GET COLD SORES? Y N

**FEMALE PATIENTS**

ARE YOU PREGNANT OR BREAST-FEEDING? Y N

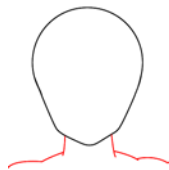
DO YOU HAVE REGULAR PERIODS? Y N

HAVE YOU OR ARE YOU CURRENTLY GOING THROUGH MENOPAUSE? Y N

DURING PREGNANCY DID YOU EVER HAVE PROBLEMS WITH DARKENING OF YOUR SKIN? Y N

HAVE YOU EVER HAD SKIN CANCER? Y N

IF YES, PLEASE LIST TYPE OF CANCER AND MARK LOCATION ON HEAD, FACE, NECK AND DECK



**PERSONAL SKIN CARE INFORMATION (ck mark please)**

BAR SOAP \_\_\_\_\_ CLEANSER \_\_\_\_\_ TONER \_\_\_\_\_ GLYCOLIC \_\_\_\_\_

MASQUE \_\_\_\_\_ MOISTURIZER \_\_\_\_\_ OTHER \_\_\_\_\_ SCRUBS \_\_\_\_\_

ANY SPECIAL SKIN PROBLEMS? \_\_\_\_\_

**HOW DO YOU WANT TO IMPROVE YOUR SKIN?**

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**FREE RADICAL EXPOSURE**

DO YOU SMOKE?	Y	N		
DO YOU CONSUME ALCOHOL?			Y	N
DO YOU EAT A HEALTHY DIET?			Y	N
DO YOU EXERCISE?	Y	N		
DO YOU TAKE VITAMINS?	Y	N		

**SUN (circle one please)**

I	BURN	II	USUALLY BURN
III	SOMETIMES BURN	IV	RARELY BURN
V	NEVER BURN-BROWN	VI	NEVER BURN-BLACK

**ACNE (check what applies please)**

DO YOU HAVE FREQUENT BREAK OUTS? Y N

PIMPLES \_\_\_\_\_ WHITEHEADS \_\_\_\_\_ BLACKHEADS \_\_\_\_\_ CYSTS \_\_\_\_\_

ENLARGED PORES \_\_\_\_\_ FLAKINESS \_\_\_\_\_ ACNE SCARS \_\_\_\_\_

DRY \_\_\_\_\_ OILY \_\_\_\_\_ TIGHTNESS \_\_\_\_\_ T-ZONE \_\_\_\_\_ FLAKINESS \_\_\_\_\_ WRINKLES \_\_\_\_\_

**WHAT AREAS WOULD YOU LIKE TO TREAT? (ck mark please)**

FACE \_\_\_\_\_ NECK \_\_\_\_\_ CHEST \_\_\_\_\_ FOREARMS \_\_\_\_\_ OTHER \_\_\_\_\_