



The Dharma Center

Patient Skin Care Form

Name (Last, First) : _____ Initial Appointment Date: _____

Address: _____ City : _____ State: _____ Zip Code : _____

Phone (H) _____ (W) _____ (C) _____ Preferred Contact: H W C

Email Address: _____ Date of Birth: _____

Referred By: _____

Known Medications that will affect your skin care therapy. Are you **using** to any of the following?

- Accutane Retin-A Renova Benzoyl Peroxide Alpha Hydroxy or Glycolic Acid
- Other Skin Medications (please list) _____
- Birth Control or other Hormone Replacement Products Appetite Suppressors Antibiotics
- Other Medications (Please List) _____

Known allergies that will affect your skin care therapy. Are you **allergic** to the following?

- Food Bees or Bee Products Drugs or Medications Essential Oils Fragrances
- Other (please list) _____

Known Medical Conditions that will affect your skin care therapy. Please check all that apply.

- Pregnant Breast Feeding High/Low Blood Pressure Heart Condition Cancer Epilepsy Diabetes
- Asthmatic Active Herpes Thyroid Condition Fibromyalgia Recent Surgeries or Injuries
- Others that may affect products used or the pressure with which they are applied to the skin? : _____

***** Inform your aesthetician if you are menstruating or if your skin is sensitive to touch and/or heat *****

Do you wish for us to gather or share medical records regarding this treatment?:

- Yes No (if yes please fill out our hipaa release form.)

Information and Signatures

I understand that aestheticians do not diagnose illness or disease, nor do they prescribe medical treatment. I have stated all medications and medical conditions that I am aware of and I will update the aesthetician of any changes in my health status.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____