SKIN CONSULTATION FORM

Name: _____

Birthday: _____

Age: _____

Address: _____

Contact #: _____

Email address: _____

SKIN ANALYSIS

SKIN TYPE

☐ Dry ☐ Combination ☐ Patchy

☐ Oily ☐ Sensitive ☐ Extreme Sensitive

Allergies

☐ Yes ☐ No Details:_____

Medication

☐ Yes ☐ No Details:_____

Surgery

☐ Yes ☐ No Details:_____

Skin Conditions

☐ Yes ☐ No Details:_____

Other

☐ Yes ☐ No Details:_____

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