Epionce Client Questionnaire

Title: ___________ Name: ____________________________________ Date of Birth: __ / __ / _____

Address: ____

____ Postcode: ____________________

Day Telephone Number: ____

Evening Telephone Number: ____

Mobile Telephone Number: ____

Email Address: ____

Are you currently seeing your doctor for any medical condition? ……………………………………. Yes / No

Are you taking any medication (topical or oral)? …………………....………………………………… Yes / No

Have you any allergies? Including Salicylic/aspirin, nut or latex ……………………………………... Yes / No

Have you ever has a skin allergy/reaction after treatment? ……………………………………….... Yes / No

Have you ever seen a Dermatologist? …………………………………………………………….. Yes / No

Do you have a history of cold sores or lip herpes? ………………………………………………… Yes / No

Have you under gone any facial cosmetic procedures? …………………………………………… Yes / No

Have you ever had chemotherapy/radiotherapy? …………………………………………………… Yes / No

Could you be pregnant, planning a pregnancy or breastfeeding? ………………………………… Yes / No

During pregnancy, did you get hyper pigmentation or masking? ………………………………… Yes / No

Do you sunbathe or use sun beds? ………………………………………………………………… Yes / No

Do you suffer from Claustrophobia? ……………………………………………………………… Yes / No

Do you suffer with Asthma or any bronchial conditions? ………………………………………….. Yes / No

Do you wear contact lenses? …………………………………………………………………….. Yes / No

Do you undertake any exercise? ………………………………………………………………….. Yes / No

Do you smoke? If yes, how many ………………………………………………………………… Yes / No

What is your current skin care regime? Please list all products you use on your skin:

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