



Be Bright. Be Beautiful.

Confidential Skin Health History

Please answer the following confidential questions so that we may have a better understanding of your general health and lifestyle, thereby enabling us to accurately analyze and assess your skin care needs.

PERSONAL INFORMATION

Name _____

Date of Birth _____/_____/_____

Address _____

City _____ State _____ Zip _____

Best Contact Number _____ Is it ok to text this number? ☐ Yes ☐ No

Email _____

FACTORS THAT EFFECT SKIN HEALTH

1. Are you a smoker? ☐ Yes ☐ No

2. Are you pregnant? ☐ Yes ☐ No

3. Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, for what condition(s)? _____

Allergies _____

Have you been diagnosed or treated for the following within the last 24 months? (check all that apply)

☐ Eczema ☐ High blood pressure ☐ Cancer ☐ Psoriasis ☐ Blood clots

☐ Acne ☐ Hormone therapy ☐ Cold Sores ☐ Diabetes

☐ Other _____

What medications and supplements are you currently taking? _____

Your daily stress level is: ☐ Mild/Low ☐ Medium/Average ☐ High/Intense

Occupation _____

How many ounces of water do you drink per day? _____ How often do you exercise? _____

Do you have any metal implants in your body? ☐ Yes ☐ No

If yes, where? _____

YOUR SKIN

What is the primary reason for your visit today? _____

What is the most important improvement you would like to see in your skin? _____

Please list any cosmetic procedures you have had in the last 12 months _____

What skincare line are using? _____

Describe your daily skin care routine _____

How often do you wear sunscreen? ☐ Everyday ☐ Occasionally ☐ Only when I'm outside

Have you received any of the following procedures within the last 6 months?

☐ Microdermabrasion ☐ Facial Injections (Botox, Fillers) ☐ Derma-plane ☐ Waxing

☐ Micro-needling (CIT, PRP) ☐ Laser Procedures

☐ Other _____

I understand the information I have provided above is true and correct. I also understand that all information stated is strictly confidential and will not be shared outside of this facility due to HIPPA regulations.

Signature _____ Date _____



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TOTAL SCORE	FITZPATRICK TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

Fitzpatrick Scoring Test

Genetic Disposition Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin? (non exposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total Score for Genetic Disposition: _____

Reaction to Sun Exposure Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely Burns	Never Burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total Score for Reaction to Sun Exposure: _____

Tanning Habits Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	Over 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score for Tanning Habits: _____



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Informed Consent Form

Name _____ Date _____

The instructions and guidelines provided in this informed consent should be followed by all individuals receiving a professional service. Please read and initial after each paragraph acknowledging that you have read and understood all of the information presented.

PROFESSIONAL ESTHETIC IN-CLINIC SERVICE

1. This professional esthetic in-clinic service is designed to improve the texture and appearance of your skin. Your participation in your service will determine the outcome. It is important that you strictly adhere to all instructions that your skincare therapist will provide.
2. Depending on the service, you may experience some temporary erythema, irritation, or warm flushing. During the next few hours, you may experience some tightening of the skin which may last for several days.
3. For some individuals, a light flaking begins within 48 hours. It is impossible to pre-determine how much flaking will occur.
4. Depending on the service, the sloughing process usually subsides within 2-7 days.
5. Pigment may appear darker on the surface before fading.
6. Lack of flaking or "peeling" is NOT an indication that the service was unsuccessful. If you do not notice actual peeling, you are still receiving all the benefits of your service such as improvement of skin tone, texture, and appearance of fine lines and hyperpigmentation. There are a number of reasons why some people may not experience peeling.
7. Results may vary with each service and individual client.

I ACKNOWLEDGE I DO NOT HAVE THE FOLLOWING

- | | |
|---|--|
| <input type="checkbox"/> I am not pregnant. | <input type="checkbox"/> Active cold sores |
| <input type="checkbox"/> No sunburns in the last 7 days | <input type="checkbox"/> Not taken Accutane (or its generic form) within the last 6 months |
| <input type="checkbox"/> Not allergic to aspirin | <input type="checkbox"/> No new allergies or sensitivities since my last visit |

PRE-SERVICE GUIDELINES - Unless otherwise instructed to do so by your skincare therapist:

- _____ 1. I acknowledge I have followed the pre-service guideline of: One week prior to service avoid waxing, electrolysis, Laser Hair Removal, prescription retinoids/retinoid-like compounds (Retin-A, Renova, Differin, Tazorac), products containing any exfoliating agents that may sensitize the skin.
- _____ 2. Please advise of any medical cosmetic facial procedures within the last 14 days.

POST SERVICE GUIDELINES - Post care is the continuation of your in-clinic service.

- _____ 1. It is essential to follow the post service home care program as recommended by your skincare professional. This will include daily SPF protection.
- _____ 2. Avoid direct sun exposure, strenuous exercise, or high amounts of heat including saunas and hot tubs
- _____ 3. Do not pick or pull the skin.
- _____ 4. Immediately notify your skincare therapist of any concerns.

CONSENT

I hereby give my consent & authorization, and voluntarily release _____ from any claims implied or stated that I have or may have in the future with this service, regardless of result. I am stating that the service and precautions above have been explained to me in detail and that I fully understand. If I am under the care of a physician, I have discussed the service plan with my physician for prior approval.

Signature _____ Date _____



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Model/Photo/Video Release

Date _____

I hereby irrevocably consent to and authorize the use and reproduction by Lira Cosmeceutical/Lira Clinical or anyone authorized by you, of any and all photographs or video/film, which you have taken of me for any purpose whatsoever, without further compensation to me. All images and/or video/film/digital assets shall constitute your property, solely and completely.

Model Name _____

Model Signature _____

Address _____

City _____

State Zip _____

Phone (_____) _____



Signature of Parent of Guardian if Model is a minor _____

Witnessed by _____