epionce®

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 had a skin allergy / reaction after treatment? ..... **Yes / No**

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

Do you use any topical medications? ..... **Yes / No**

Have you under gone any cosmetic procedures? ..... **Yes / No**

Have you ever had chemotherapy / radiotherapy? ..... **Yes / No**

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

Could you be you 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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