



**BELLA VIA**  
Skin and Body Therapies

# SKINCARE TREATMENTS FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable)

Dr. Colville      Dr. Zavell      Website      Friend: \_\_\_\_\_

Other: \_\_\_\_\_

Airline Travel:    Yes    No    How Frequently: \_\_\_\_\_

## SKIN SPECIFICS

What are your expectations of the skin treatment you will receive today? \_\_\_\_\_

If time allows, would you like to add any extra services to your skincare procedure today, such as waxing or paraffin for the hands and/or feet? \_\_\_\_\_

How would you describe your skin? (circle all that apply)

Acne Scarred	Asphyxiated	Breakouts	Combination	Comedones
Cysts	Dry	Firm	Florid/Flushed	Freckled
Hyperpigmented	Hypopigmented	Large Pores	Mature	Melasma
Milia	Normal	Oily	Oily T-Zone	Patchy Dryness
Perfume-Stained	Psoriasis	Rosacea	Saggy	Sallow/Yellowed
Small Pores	Sun-Damaged	Thick	Uneven	Wrinkled

Telangiectasia (Broken Surface Capillaries)

What type of skin do you have?	Sensitive	Resilient	Unsure
Are you sensitive to alcohol-based products?	Yes	No	
Have you ever had a peel?	Yes	No	
Have you had a peel within the last 14 days?	Yes	No	
If yes, please describe the type and your reactions to the peel	_____		
Are you currently having microdermabrasion?	Yes	No	
If yes, how long has it been since your last treatment?	_____		
Have you recently had laser resurfacing?	Yes	No	
If yes, please describe type and list approximate date	_____		
Do you have regular collagen injections?	Yes	No	
Do you have regular Botox injections?	Yes	No	
Are you currently using Accutane?	Yes	No	
If yes, how long have you been using it?	_____		
Are you currently using Tazorac, Retin-A, Renova, or Differin?	Yes	No	
If yes, what strength?	_____	How long?	_____
How frequently?	_____	Where do you apply it?	_____
Are you currently using Bioré/snore strips?	Yes	No	

**HEALTH AND LIFESTYLE**

Do you wear contact lenses? Yes No  
Do you tan via artificial tanning beds or booths? Yes No  
If yes, when was your last visit? \_\_\_\_\_

Do you participate in vigorous aerobic activity or sports? Yes No  
Are you pregnant or lactating? Yes No  
(If yes, you may only receive the Oxy Trio or Detox treatment.)

Have you had your hair colored in the last 3 days? Yes No  
Do you plan on getting your hair colored in the next 3 days? Yes No  
Do you use a buff-puff to cleanse your face? Yes No  
If yes, how often? \_\_\_\_\_ Has it been within the last 3 days? \_\_\_\_\_

Have you had facial waxing within the last 3-5 days? Yes No  
Have you shaved your face within the last 3-5 days? Yes No  
Do you smoke? Yes No  
Do you develop cold sores and/or fever blisters? Yes No  
If yes, when was your last breakout? \_\_\_\_\_

Do you currently have a sunburned/windburned/red face? Yes No  
If yes, please list reason: \_\_\_\_\_

Please circle all allergies and/or sensitivities:  
Aloe Vera Apples Aspirin Citrus Grapes Hydroquinone  
Latex Milk Perfumes Other: \_\_\_\_\_

Please list all drug allergies: \_\_\_\_\_

What is your eye color? \_\_\_\_\_  
What is your natural hair color? \_\_\_\_\_

What is your skin tone? Pale/Fair Light Medium Reddish  
Freckled Light Olive Medium Olive Dark Olive Light Brown  
Medium Brown Dark Brown Soft Black Black Sallow/Yellowed

What is your skin heritage? Irish/English Nordic Russian Middle-Eastern  
Hispanic African Asian Italian

Have you ever used any skincare products that caused a negative reaction? Yes No  
If yes, please list products and describe reaction: \_\_\_\_\_

\_\_\_\_\_

List all skincare products that you are currently using: \_\_\_\_\_

\_\_\_\_\_

List all medications, herbals, and vitamins that you are currently taking: \_\_\_\_\_

\_\_\_\_\_

List all surgeries that you have had within the last five years and their approximate dates: \_\_\_\_\_

\_\_\_\_\_

Do you have or have you had any other medical condition(s) that your aesthetician should know about?  
If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

What cosmetic improvements would you like to see in your skin? \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for visiting Bella Via!**



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