



**NUVO**  
SALON & SPA

## Guest Health History Skincare Treatments

### Personal Information

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about NUVO? \_\_\_\_\_

**For your safety and well-being, we would like you to answer a few health-related questions. This information will remain confidential.**

What are your primary skin concerns? \_\_\_\_\_

Do you have history of chronic acne? **Yes** **No** Chronic skin sensitivity? **Yes** **No**

If yes, Please explain. \_\_\_\_\_

Do you have a history of any allergies (this includes medications, food fabrics, etc.)? **Yes** **No**

If yes, please explain. \_\_\_\_\_

Have you ever taken Accutane? **Yes** **No**

Please list any oral medication or supplements you are taking. \_\_\_\_\_

Do you have a history of cold sores? **Yes** **No**

If yes, how frequently? \_\_\_\_\_

Have you used facial waxes or depilatories in the past 3-4 weeks? **Yes** **No**

Do you use Retinol creams, Retin A or other topical or oral skin medication? **Yes** **No**

If yes, please explain. \_\_\_\_\_

**Please list any medical conditions you may have.**

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had facial peels, laser rejuvenation or microdermabrasion/dermabrasion? **Yes** **No**

If yes, please explain. \_\_\_\_\_

Do you wear contact lenses? **Yes** **No**

Do you use SPF? **Yes** **No** If yes, how often? \_\_\_\_\_

