DAVINCIA®

GENERAL HEALTH BACKGROUND

FIRST NAME _____ LAST NAME _____

ADRESS _____

CITY _____ ZIP CODE _____

PHONE NUMBER _____ PROFESSION _____

EMAIL _____ DATE OF BIRTH _____

GENDER ☐ F ☐ M ☐ ND

How did you discover Davincia, and who referred you?
Social media, website, Magazine, school, Congress, Professional, friend)

_____

Do you suffer or have you ever suffered chronically from :

- ☐ Skin hypersensitivity
- ☐ Psoriasis
- ☐ Acne (pimples or rash)
- ☐ Herpes
- ☐ Eczema
- ☐ Allergies (fluor, cobalt, nickel), tincture, detergent
- ☐ Inherited predisposition
- ☐ Vitiligo
- ☐ Thyroïd disorder
- ☐ Endocrine problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ High/Low blood pressure
- ☐ Kidney disorders
- ☐ Heart problems (pacemaker)
- ☐ Venous insufficiency/Variscoses veins
- ☐ Phlebitis (Raynaud's syndrome)
- ☐ Infectious diseases
- ☐ Cancer
- ☐ HIV
- ☐ Arthritis/Osteoarthritis/Bone calcification
- ☐ Tendonitis/ Bursitis/ plantar fasciitis
- ☐ Althete's foot
- ☐ Onychomycosis (nail fungus)
- ☐ Autres :

When was your last blood test? (If possible, please attach a copy) :

_____

Are you currently taking or have you taken any of the following medications in the past six months?

- ☐ Anticoagulants
- ☐ Accutane
- ☐ Synthroid
- ☐ Hormones (any other hormone therapies)
- ☐ Cortisone (nasal spray, cream for ezcema)
- ☐ Antibiotics (doxicicline)
- ☐ Others :

Have you undergone surgery or anesthesia in the past six months? Date:

_____

Have you followed or are you currently following a diet in the past year? (vegan, keto, low FODMAP, etc.)

_____

_____

Do you have any diagnosed nutritional deficiencies? (Anemia, B12, Proteins, etc.)

_____

_____

Have you ever used:

	YES	NO	If so, when (date) / how many time / results (satisfaction) ?
UV lamps (tanning)	☐	☐	
Laser/IPL	☐	☐	
Botox/Injections	☐	☐	
Tattooing/Permanent make up	☐	☐	
Radiotherapy	☐	☐	
Chemical peel	☐	☐	
Microneedling	☐	☐	
Microdermabrasion	☐	☐	
AHA cream	☐	☐	
PRP	☐	☐	
Scalp treatment	☐	☐	
Hair treatment	☐	☐	
Hair transplant	☐	☐	

For women only:

- ☐ Pregnant
- ☐ Hormonal contraception (pill)
- ☐ Irregular menstrual periods
- ☐ IUD (intrauterine device)
- ☐ Currently in menopause
- ☐ Pre-periménopause
- ☐ Endometriosis
- ☐ Hormonal disorders

How often do you use your beauty products?

- ☐ Every day
- ☐ 1 to 5 times a week
- ☐ 1 to 5 times per month

What issues would you like to address?

SKIN FACE

- ☐ Dry skin
- ☐ Oily skin et excess sebum
- ☐ Blackheads
- ☐ Pimples or rash
- ☐ Dull complexion
- ☐ Enlarged pores
- ☐ Dark/brown spots
- ☐ Redness
- ☐ Wrinkles
- ☐ Skin laxity
- ☐ Dark circles under the eyes
- ☐ Under-eye puffiness
- ☐ Scars
- ☐ Eczema
- ☐ Psoriasis

BODY

- ☐ Cellulite
- ☐ Fat deposits
- ☐ Spider veins
- ☐ Heavy legs / Edema
- ☐ Restless legs syndrome (RLS)
- ☐ Dimples

SCALP AND HAIR

- ☐ Dry scalp
- ☐ Oily scalp
- ☐ Psoriasis
- ☐ Alopecia
- ☐ Seborrheic keratosis
- ☐ Dandruffs
- ☐ Itching
- ☐ Eczema
- ☐ Ringwormn (tinea)
- ☐ Baldness
- ☐ Dermatitis
- ☐ Hair loss (androgenetic alopecia) therapomedic
- ☐ Other:

Do you occasionally or on a daily basis wear a wig or come into contact with wig adhesive?

- ☐ Yes
- ☐ No
- ☐ Occasionally

How often do you wash your hair?

- ☐ Every day
- ☐ Every 48 hours
- ☐ Every 72 hours of more

What are your lifestyle habits?

QUALITY OF SLEEP

- ☐ Good
- ☐ Frequent waking
- ☐ Bad
- ☐ Insomnia
- ☐ Hypersomnia

QUANTITY OF SLEEP

- ☐ 0 - 2 hours
- ☐ 3 - 6 hours
- ☐ 7 - 9 hours
- ☐ More than 10 hours

MEALS

- ☐ Low appetite
- ☐ Strong appetite
- ☐ Normal satiety
- ☐ Binge eating
- ☐ Eating disorder:

EMOTIONAL SHOCK (STRESS)

- ☐ Yes, date :
- ☐ No

SOCIAL ACTIVITIES

- ☐ Occasional to regular
- ☐ Every day
- ☐ Loneliness

HOURS OF WORK PER WEEK

- ☐ Less than 20 hours
- ☐ 30 to 40 hours
- ☐. 40hours or more
- ☐. Retired
- ☐ Sick leave
- ☐ Unemployed

PHYSICAL ACTIVITY

- ☐. Every day
- ☐ 1 to 3 times per week
- ☐ 4 to 6 times per week
- ☐. Occasionally

On a scale of 1 to 10, how satisfied are you with your daily life currently?

_____

Which brand(s) of beauty products (face, body, and/or hair) are you currently using?

_____

_____

Are there any places you don't like to be touched or have a sensitivity to touch? (tactophobia)

_____

_____

What percentage of results and what do you wish to achieve with Davincia® products?

_____

Are there any other relevant information you believe should be provided to your professional?

_____

_____

_____

_____

I, the undersigned, declare that the information provided here is truthful. I commit to informing the professional of any future changes in my habits, health conditions, and/or medication intake. I understand that photos will be used to assess my progress.

_____ _____

SIGNATURE DATE