SUBJECTS IDENTIFICATION SHEET

SURNAME : (1 letter per box)

FIRST NAMES : (1 letter per box and a space between 2 first names)

SEX* : ☐ M. ☐ F.

BIRTH DATE : _____ **AGE :**

BIRTH PLACE :

ADDRESS :

N°

Street

Postal code

City

TELEPHONE NUMBER :

Home : (compulsory) **Work** **Cell**

E-MAIL ADDRESS :

@

HEIGHT: , m **WEIGHT :** Kg

INFORMATION **L I B**

Medication		*Phototype*	*I II III IV V*
Contraception		*Soap*	*No problem* *Irritates*
History of Atopy	*Eczema* *Asthma* *Conjunctivitis* *Allergic rhinitis*	*Sensitive skin*	*Yes* *No*
Nature of skin	*Normal* *Oily* *M ixed oily* *Dry* *Mixed dry* *Very dry*	*Fragile*	*Cold* *Wind* *Sun*
Prone to acne	*Yes* *No*	*Previous reaction to cosmetic product*	*Yes* *No*

Date of completion: _____ Initial of staff member : _____ ID verification ☐

VOLUNTEER NAME_____

CODE : |__|__|__| |__|__|

GENERAL QUESTIONNAIRE

- Any medical problems?

. Cardiac	:	|___|
. Pulmonary	:	|___|
. Digestive	:	|___|
. Hepato-vesicular	:	|___|
. Neurologic	:	|___|
. Psychiatric	:	|___|
. Renal	:	|___|
. Urinary	:	|___|
. Hematologic	:	|___|
. Endocrinologic (hormones)	:	|___|
. Known diabetes	:	|___|
. Dermatological	:	|___|
. Ophthalmological	:	|___|

If YES give details _____

Did you ever undergo an operation? YES NO

If YES state precise date and reason_____

Do you regularly practice sport ? |___|

If yes, which one ?

swimming |___|

dance |___|

judo |___|

boxing |___|

others (please precise) |___|

For the female volunteers

Do you practice effective birth control, when necessary ? |___|

Are you pregnant or nursing at the moment ? |___|

Are you on medication? (detail any medication that you take on a daily basis)

1._____ Reason_____

2._____ Reason_____

3._____ Reason_____

4._____ Reason_____

5._____ Reason_____

Any allergic diseases in your family ? |___|

If yes, who ?

Father |___|

Mother |___|

Brother |___|

Sister |___|

others (please precise) |___|

Did you ever suffer from one of the following?

Eczema : |___| Contact eczema : |___|

If yes, where ?
Thorax |___| Arms |___| Hands |___| Legs |___|

Feet |___| Face |___| Scalp |___| Neck |___| .

Neckline |___|

Do you have severe reactions to insect bites ? |___|

Have you ever had the following?

1. *Constitutionnal eczema appearing more often during childhood* |___|

If yes, location ?

Elbow folds |___| Knees folds |___| Others (precise) |___|

2. *Recurrent cyclic asthma* |___|

3. *Recurrent cyclic conjunctivitis* |___|

4. *Documented rhinitis* |___|

If yes, origin ?
Pollen |___| Acarids |___| Animals |___| Others(precise) |___|

If yes, during which period of the year ?
Winter |___| Spring |___| Summer |___| Autumn |___|

Do you suffer from intolerance to one of the following foods ?

If yes, please tick the appropriate one

. Fish |___|	. Shell-fish |___|	. Milk |___|
. Banana |___|	. Kiwi |___|	. Peach |___|
. Green peas |___|	. Beans |___|	. Cheese |___|
. Eggs |___|	. Avocado |___|	. Peanuts |___|
. Celery |___|	. Carots |___|	. Others (precise) |___| →

Have you already developed an intolerance or allergical reactions to the following product(s) or drug(s) ?

If yes, please tick the appropriate one

. Aspirin |___|	. Penicillin |___|	. Sulpha drugs |___|
. Tartrazine |___|	. Mercurochrome |___|	. Mercryl laurylé |___|
. Iodized alcohol |___|	. Betadine |___|	. Others : (precise) |___| →
. Latex |___|		

Have you ever developed skin reactions when in contact with the following products ?

If yes, please tick the appropriate one

. Costume jewellery |___|	. Denims stud |___|	. Hair products |___|
.Detergents |___|	. Rubber |___|	. Disinfectant |___|
.Cement |___|	. Paint |___|	. Plastic |___|
. Glue |___|	. Varnish |___|	. Wood |___|
.Textile |___|	. Colophany |___|	. Nickel |___|
.Aluminium |___|	. Adhesive plaster |___|	. Others : (precise) |___|

Have ever had a reaction to cosmetics? : |___| (abnormal reaction to the usual cosmetic products).
eg. moisturisers, toners, eye make up, foundation, face masks, shampoos, deodorants etc

If yes, please precise

sensation of prickling |___| peeling |___|

sensation of heat |___| sensation of burning |___|

other |___| _____ (eg tightness)

Have you ever developed a reaction

. to perfume? |___|

Have you ever suffered from itching after

. exposure to sun ? : |___|

. a shower ? : |___|

. exposure to cold ? : |___|

Have you ever developed a reaction

. to dying, bleaching or perming products? |___|

Do you use a moisturising cream ? |___|
If yes, please precise :

Application area :

face |___| arm |___| legs |___| body |___|

Do you use an anti-wrinkle cream ? |___|

Do you regularly use a deodorant ? |___|

If yes, please precise :

with alcohol |___| without alcohol |___| sensitive skins |___|

Type
aerosol (with gas) |___| spray (without gas) |___|

stick |___| roll-on |___|

others (precise) _____

<u>For the female volunteers</u>

Do you regularly remove the hair from your armpits? |___|

If yes, please precise :

wax |___| depilatory product |___| electrical epilator |___|

mechanical shaver |___| electrical shaver |___|

Do you regularly remove the hair from your legs? |___|

If yes, please precise :

wax |___| depilatory product |___| electrical epilator |___|

mechanical shaver |___| electrical shaver |___|

For the male volunteers

Do you regularly shave ? |___|

. If yes, please precise :

mechanical shaver |___| electrical shaver |___|

If yes, do you apply an after-shave product ? |___|

. If yes, please precise :

lotion |___| cream |___| gel |___|

Gender M. |___| F. |___|

Height (cm) _____

Weight (kg) _____

Smoking |___|

(less than 10 cigarettes per day to be on a trial)

Regular intake of alchoholic drinks |___|

(drinking in moderation whilst on a trial)

Tolerance to sun (without any protection)

Phototypes

I turns red, burns and does not get tanned |___|

II turns red, burns and sometimes gets slightly tanned |___|

III turns red frequently but slightly, then gets tanned more or less moderately |___|

IV sometimes turns red, then gets moderately tanned |___|

V hardly turns red, gets intensively tanned |___|

V volunteer of black race : non-sensitive skin |___|

Face skin

Types

normal |___|

dry |___|

very dry |___|

mixed with a dry tendency |___|

mixed with an oily tendency |___|

oily |___|

Use of soap

- without any problem |___| - tolerated but slightly dries the skin |___|

- dries and/or irritates the skin (redness, tugging, prickling) |___| - marked intolerance |___|

Do you ever have problems with your skin after the following (itching, burning, prickling or general discomfort)

. exposure to cold |___|

. exposure to wind |___|

. extreme sun exposure |___|

. after repeated washing of the skin |___|

Is you skin prone to acne? |___|

- Presence of acne |___|

. forehead |___| cheeks |___| nose |___| chin |___|

. severity : + |___| ++ |___| +++ |___|

Lips

- Normal |___| - Sensitive |___| - Fragile |___|

- Dry |___| - Cracked |___|

Skin of the back

Nature normal |___| dry |___| oily |___|

mixed |___| prone to acne |___|

Skin of the hands

Nature normal |___| dry |___| sensitive |___|

oily |___| mixed |___|

Skin of the forearms (internal side)

Nature normal |___| dry |___|

oily |___| mixed |___|

Skin of armpits

sensitive |___| prone to irritation |___|

Stretch marks |___| .

If yes, please precise :
location : stomach |___| thighs |___| hips |___| breasts |___|

severity : + |___| ++ |___| +++ |___|

Scars |___|

If yes, please precise

location : back |___| face |___| arms |___| forearms |___|

stomach |___| waist |___| legs |___|

severity : + |___| ++ |___| +++ |___|

Burns |___|

If yes, please precise

location : back |___| face |___| forearms |___| arms |___|

stomach |___| waist |___| legs |___|

severity : + |___| ++ |___| +++ |___|

Skin colour (flesh-tint)

- albino |___| - milk-like |___| - light |___|

- mat |___| - black |___| - intermediate |___|

Eye colour

- blue |___| - green |___| - brown |___|

- grey |___| - black |___|

Natural hair colour

- white |___| - red |___| - blonde |___| - light brown |___|

- dark brown |___| - brown |___| - black |___|

Hair

- Normal |___| - Brittle |___| - Dry |___| - Oily |___|

Scalp

- Normal |___| - Dry |___| -Sensitive (prickling, itching) |___| - Oily |___|

Sebumetric values

Forehead_____

Cheek_____

Forehead	Cheeks	Hands (top)	Neck, body
< 99 dry	< 66 dry	< 6 dry	< 66 dry
99-220 normal	66-176 normal	> 6 not dry	67-110 normal
> 220 oily	> 176 oily		> 110 oily

Do you wear glasses? |___|

Do you wear contact lenses? |___|

Are you eyes sensitive to any of the following?

Wind |___|

Sun |___|

Pollution |___|

Cosmetics |___|

Shower/swimming |___|