Skin and Health Questionnaire

Please answer the following questions thoroughly and completely, as this provides a better understanding of your general health, lifestyle and skin care concerns; thereby enabling the best treatment and home care recommendations.

Name: _____ **DOB:** _____

Address: _____

Occupation: _____ **Email:** _____

Cell Phone: _____ **Alternative Phone:** _____

Let us thank the person who referred you_____

Skin Care History

If there was something you could change or improve about your skin, what would it be?

_____

What else? Please check all that apply:

- Discoloration (Brown Spots or Melasma)
- Fine Lines & Wrinkles
- Dry, Flaky Skin
- Oily Skin
- Acne/Breakouts
- Acne Scarring
- Enlarged Pores
- Rosacea
- Dilated Capillaries
- Redness (Reactive Skin)
- Uneven Texture
- Sun Damage
- Loss of Facial Contours
- Lax or Sagging Skin
- Dark Under-Eye Circles

What type of skin do you think you have?

_____Dry _____ Normal _____Combination _____Oily

If oily, are you oily throughout the cheek area? Yes_____ No_____

Do you have a history of acne? Yes_____ No_____

If yes, are you using or have you ever used any medications for acne? Yes_____ No_____

Name of medication_____

Do you sunbathe or participate in outdoor activities? Yes_____ No_____

Have you ever had a reaction to any skin care product or cosmetic? Yes_____ No_____

If yes, please list_____

What skin care do you currently use?

Morning	Evening
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Please check if you are currently using or have used any of the following:

- ○ Retinol
- ○ Glycolic Acid
- ○ Lactic Acid
- ○ Salicylic Acid
- ○ Citric Acid
- ○ Resorcinol
- ○ Benzoyl Peroxide (BPO)
- ○ Hydroquinone
- ○ Tretinoin (Retin A®, Renova®, Refisa®)
- ○ Topical Antibiotics
- ○ Topical Steroids
- ○ Adapalene (Differin®)
- ○ Azelaic Acid (Azelex®, Finacea®)
- ○ Isotretinoin (Accutane®)

Have you ever, or are you currently receiving skin treatments? Yes_____ No_____

Have you had any of the following?

- ○ Chemical Peels
- ○ Laser Resurfacing
- ○ Facial Cosmetic Surgery
- ○ Facial Injectibles
- ○ Permanent Cosmetics
- ○ Light Treatments
- ○ Microdermabrasion
- ○ Dermaplanning
- ○ Extractions
- ○ Electrolysis
- ○ Laser Hair Removal
- ○ Waxing

If yes, when was your last treatment? _____

Were there any complications? Yes_____No_____

If yes, please explain _____

General Health

Are you currently under the care of a physician? Yes_____ No____

If yes, please discuss contraindications of any pre-existing medical conditions with your physician.

Are you currently taking any medications? Yes_____ No_____

If yes, please list here_____

Female Clients

Are you on hormone – replacement therapy? Yes_____ No_____

Are you currently taking birth control pills? Yes_____ No_____

Are you pregnant or breast feeding? Yes_____ No_____

Please check the following conditions you have, or have had, in the treatment area:

- Dermatitis
- Eczema
- Psoriasis
- Open Sores or Lesions
- Cold Sores/ Fever Blisters
- Actinic Keratosis
- Keloid Scarring

Are you allergic to aspirin? Yes_____ No_____

If you have any known allergies, please list them:

_____

Is there anything else that should be known before starting your treatment?

_____

_____

_____ _____

Signature Date