SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.

Name *(please print clearly)*

Date ____/____/____

Date of Birth

____/____/____

First Last M.I.

Street Address

City **State** **Zip Code**

Home Phone **E-Mail Address**

( )

Please check if presently using any of the following? *(please ✓ all that apply)*

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid

❑ Hydroquinone ❑ Any prescription strength topical i.e. steroids, Retin-A, Tazorac, Differin, etc.

Which conditions do you want to improve *(please ✓ all that apply)*

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores

❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone replacement therapy? ❑ Yes ❑ No

Are you presently taking birth control pills? ❑ Yes ❑ No

Are you pregnant or planning to be? ❑ Yes ❑ No

ALL CLIENTS

Do you use a sunscreen/sun block? ❑ Yes ❑ No

Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you have or have ever had acne? ❑ Yes ❑ No

Are you using or have ever used any medications for acne? ❑ Yes ❑ No

Name of medication _____

Have you seen a Dermatologist in the past year? ❑ Yes ❑ No

If yes, list doctors name and reason for visit _____

Are you presently under a doctor's care? ❑ Yes ❑ No

What medications do you take on a regular basis? _____

Have you ever had Herpes (cold sores)? ❑ Yes ❑ No

Have you ever been treated with Zovirax or any medication for Herpes? ❑ Yes ❑ No

SKIN CARE HISTORY QUESTIONNAIRE

Do you have Epilepsy, Diabetes, or other auto-immune disorders? ❑ Yes ❑ No
If yes, you will be treated only with a doctors release!

Are you presently under a physicians care for any reason? ❑ Yes ❑ No
Explain _____

Do you use Biore or snore strips? ❑ Yes ❑ No

Have you had any of the following? ❑ Yes ❑ No *(please ✓ all that apply)*
❑ Cosmetic Surgery ❑ Botox Injections ❑ Skin Cancer ❑ Dermatitis ❑ Keloid Scarring
❑ Laser Resurfacing/IPL ❑ Chemical Peels ❑ Hepatitis ❑ Other (Specify) _____
❑ Dermal Fillers

Are you allergic to aspirin? ❑ Yes ❑ No Are you allergic to Iodine or Seaweed? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, list: _____

Do you smoke?	❑ Yes	❑ No
Do you take nutritional supplements?	❑ Yes	❑ No
Are you on a diet?	❑ Yes	❑ No
Do you exercise?	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Have you had skin treatments (facials) before?	❑ Yes	❑ No
Are you currently having facials?	❑ Yes	❑ No
Have you had electrolysis or waxing in the past week?	❑ Yes	❑ No
Do you have those services done?	❑ Yes	❑ No
Have you had permanent cosmetics?	❑ Yes	❑ No

If yes, where? _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What skin care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

Client Signature