Skin Care Questionnaire

Date: ____________

Name: _________________________ DOB: ____________

Address: ________________________________

City: ______________ State: ______________ Zip: ____________

Home #: _______________ Work ___________ Cell ______________ Email__________________________

Referred by: ____

Personal Data – circle one Smoker: Yes No Pregnant: Yes No

Cosmetic surgery: Yes No if Yes, when: _____________

Define procedure: ____

Medication: Yes No if Yes, what kind: _________

Any health problems? Yes No Describe: _________________

Any allergic reactions to medication? Yes No

Describe: ____

Do you have any allergies? _____________________________

Do you suntan? Yes No

Do you use sunscreen? Yes No

Please name the brand of product you are currently using:

Cleanser: _______________ Toner: _________________ Scrub: _________________

Moisturizer: ___________________ Mask: ____________________

Buff puff: ______________________ Other: ______________________________

Do you ever use Retin -A? Yes No What strength? ____________

Have you ever been treated with Phenol or Trichloracetic Acid?

Have you ever used Hydroquinone? Yes No

Have you ever been on Accutane? Yes No when? _______________

Have you ever had herpes, cold sore, fever blisters or keloids?

Circle all that apply and if Yes, when? _________________________

How would you characterize your skin?

Sensitive Rough Dry Oily Acne Prone

If you had one complaint about your skin what would it be? ___________

Describe your skin in 3 words: _____________, _____________, ____________