Skin Care Questionnaire

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Referred By: _____

Please check YES or NO to the following questions

- Smoker: YES ___ NO ___
- Pregnant: YES ___ NO ___
- Cosmetic Surgery: YES ___ NO ___ If YES, when and what procedures:
  _____
- Medication: YES ___ NO ___ If YES, what kind(s)?
  _____
- Any health problems? YES ___ NO ___ If YES, please explain:
  _____
- Any allergic reactions to medication? YES ___ NO ___If YES, please describe:
  _____
- Do you have any allergies? YES ___ NO ___ If YES, please explain:
  _____
- Do you suntan? YES ___ NO ___
- Do you use sunscreen? YES ___ NO ___
- Have you ever used Retin-A? YES ___ NO ___ If YES, what strength? _____
- Have you ever been treated with Phenol or Trichloracetic acid? YES ___ NO ___
- Have you ever used Hydroquinone (skin lightener) YES ___ NO ___
- Have you ever been on Accutane? YES ___ NO ___ If YES, when? _____
- Have you ever had herpes, hives, cold sores, fever blisters, keloids? YES ___ NO ___ If YES, then when?
  _____
- How would you characterize your skin? (Please check the one that applies)
  Sensitive____ Rough ____ Dry ____ Oily/Acne-prone ____
- If you had one complaint about your skin, what would it be? _____
- Describe your skin in three words: _____
- Additional comments/concerns:_____

Please name the brand of products you are currently using

Cleanser: _____ Toner: _____ Mask: _____

Moisturizer: _____ Scrub: _____ Other: _____