Skin Health Questionnaire

Client should complete the following, as directed, as thoroughly and in as much detail as possible.

Name			Date
Daytime Phone		Evening Phone	
Street Address			City
State	Zip	Email	
Birthdate	Emergency Contact		Relation to Contact
Your Physician		Phone Number	
How did you hear about us?			Occupation

INTEREST

Please indicate which services you are interested in:

☐ Skin Care Consultation/Advice	☐ ClinicalTreatments	☐ Acne Treatment/
☐ Home Care Products	☐ Age Management	Management ☐ Rosacea

☐ What do you wish to change about your skin?

Medical History

Are you currently, or have you previously experienced any of the following:

☐ Heart condition	☐ Cancer	☐ Hemophilia	☐ Herpes Simplex
☐ Pacemaker	☐ Thyroid condition	☐ Asthma	☐ AIDS/HIV Positive
☐ Headaches	☐ Kidney problems	☐ Diabetes	☐ Autoimmune
☐ Anemia	☐ High blood pressure	☐ Hypo/Hyper glycemia	Type_____
☐ Low blood pressure	☐ Arthritis	☐ Hepatitis	☐ Contact Lenses

If you are currently experiencing or being treated for any health-related condition, please describe:

Have you ever had surgical or non surgical procedure? If yes, where on your body was the surgery performed?

Do you have any allergies? Also list any skin treatment products you have used that caused an unexpected reaction or side-effect:

Please list all over-the-counter and prescription medications you are currently taking:

Please indicate if you have ever used any of the following medications for skin treatment:

☐ Accutane	☐ Retin A	☐ Fosdex	☐Renova
☐ Cortisone	☐ Sulfer	☐ Glycolic Acid	☐Clindamycin
☐ Staticin	☐ DesquamX	☐Salicylic Acid	☐Tazoratene
☐ Benzoyl Peroxide	☐ Zerac	☐ Lactic Acid	☐ Metrogel

What condition were you treating with this medication(s)?

When was the last time you used these medications?

Women

Are you pregnant? Yes No

Are you planning a pregnancy in the near future? Yes No

Are you currently on any type of hormone therapy? If yes please describe:

Do you have regular periods? Yes No Are you going through menopause? Yes No
Do you have any hormone imbalance? Yes No
Have you undergone surgical menopause (hysterectomy) Yes No When?

Skin Self-Analysis

What skin care products are you currently using?

Are you wearing a daily sunscreen? Type: SPF:

Is your skin: ☐ Oily or acne prone? ☐Dry? ☐ Normal? ☐ Sensitive?

Have you ever treated or been treated for a skin condition? If yes, what condition?

How did you treat the condition:
☐ Dermatologist ☐ Aesthetician ✷Self treated with products purchased from: ☐ Drug Store ☐ Department Store

Were you happy with the result? Yes No

Are you currently treating or being treated for any skin condition?

Lifestyle and Stress Analysis

Do you come in contact with any chemicals at work? Do you work around excessive heat or cold?

Do you use Personal Protective Equipment (PPE*)? If so, what type and for how long? *Masks, gloves, shields, etc.

How often do you exercise? Average hours of sleep What is your stress level?

How many minutes a day are you exposed to sunlight?	How many hours a week do you use a tanning bed?
Do you get cold sores?	What is your ancestory? Father Mother

Please indicate any of the following that apply to your eating habits:

☐ Fast food	☐ Salt your food	☐ Dairy products	☐ Peanut Butter
☐ Baked Bread	☐ Seafood	☐ Ethnic or Spicy foods	☐ Peanuts

How much water do you drink per day? Caffeine? Carbonated drinks?

Do you smoke tobacco products? Average alcohol consumption per week

Have you changed your brand of skin care products in the last year? If yes, why did you change?

✷**I understand and agree that I am ultimately responsible for payment in full for services received.**

Signature of Patient or Responsible Party_____

Date _____ Relationship to Patient_____