

Client Questionnaire

Your Information

Name	Age	DOB	Ethr	nicity	
Address	City		State	Zip	
Home Phone	Cell Phone	Ema	ail		

Medications

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		



Medical History (please check all that apply)

Herpes Simplex	HIV/AIDS	Hemophilia	
Eczema	Thyroid Problems	Lupus	
Psoriasis	Hormone Problems	Anemia	
Hepatitis	Hysterectomy	High Blood Pressure	
Cancer	Ovary(ies) Removed	Diabetes	
Staph Infection/MRSA	Pacemaker	Metal Pins in Body	

Your Primary Care Physician:		
Name:	Phone:	
Are you under a dermatologist's or other ph		
If yes, doctor's name:		
Lifestyle Considerations		
Have you ever had any reaction to any products or a	anything you have put on your face?	Yes 🗆 No 🗆
If yes, what products?		
Please check any of these you are allergic to: Sulfur	□ Aspirin □ Latex □	
List any other allergies you know of:		_
Do you smoke? Yes □ No □		
Do you use fabric softener or fabric softener sheets	in the dryer? Yes \square No \square	
Do you swim in a chlorinated pool? Yes \square No \square		
Do you work around chemicals, tars, oils, grease or i	nks? Yes 🗆 No 🗅	
Occupation:	Do you work nights? Yes 🗆 No 🗆	



Are you currently under a lot of stress? Yes \square No \square (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)

Women: Do you use birth control pills, shots or	r use an IUD? Yes 🗆 No 🗆
If so, which do you use?	_ What brand of pill?
Are you pregnant or nursing? Yes No	
Men: Do you have shaving irritation? Yes □	No □
What type of razor do you use for shaving?	

Diet- Do you consume the following?

Foods	1	How often per week	Foods	1	How often per week
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins		
Peanut Butter			Seafood		

Products Currently Using- Please Provide Product Names

Cleanser	
Toner	
Serums	
Moisturizers	
Sunscreen	
Mask	
Foundation	
Blush	
Exfoliant (acids, serums, scrubs)	
Acne Medications	
Anything Else?	



Other Treatments: What else have you done for your skin in the last 90 days?

Treatment	When?	Where?
Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us?
