REGENERATIVE SKINCARE QUESTIONAIRE

Patient Name: ______________________________ Today's Date: ________________

Date of Birth: ________________ Age: ________________ Occupation: ________________

Are you allergic to Latex? ☐ Yes ☐ No

Do you have any allergies or sensitivities? ☐ Yes ☐ No If yes, please list: ________________

____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list: ________________

____

____

Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements? ☐ Yes ☐ No

If yes, please list: ____

Women only: Are you pregnant, nursing, or planning a pregnancy? ☐ Yes ☐ No

Do you have any of the following:

☐ Hepatitis
☐ HIV/AIDS
☐ Active sunburn
☐ Active acne
☐ Cold sores (past or present)
☐ Autoimmune disease
☐ Open lesions
☐ Hyper or Hypopigmentation
☐ Tumors or cysts
☐ Melanoma
☐ Eczema / dermatitis
☐ Infection or rash

Have you had treatment with Accutane? ☐ Yes ☐ No When: ________________

What treatments have you received in the past:

☐ Facials
☐ Dermaplane
☐ Chemical Peels
☐ Hydrafacial
☐ Microdermabrasion
☐ CO2 Laser
☐ Microneedling
☐ RF Microneedling
☐ IPL Laser

☐ Other: ____

How would you describe your skin? ☐ Normal ☐ Dry ☐ Oily ☐ Combination

What areas of concern do you have regarding your skin?

Acne / breakouts	☐ Yes	☐ No	Sun damage	☐ Yes	☐ No
Uneven skin tone	☐ Yes	☐ No	Hyperpigmentation	☐ Yes	☐ No
Fine lines / wrinkles	☐ Yes	☐ No	Hypopigmentation	☐ Yes	☐ No
Blackheads	☐ Yes	☐ No	Dull or dry skin	☐ Yes	☐ No
Whiteheads	☐ Yes	☐ No	Rosacea	☐ Yes	☐ No

Are you currently using retinol or retinoic acid? □ Yes □ No If yes, what kind: ______________________

Date last used: ____

Please list your current skincare routine:

Cleanse	□ AM	□ PM	Type: ______________________
Exfoliate	□ AM	□ PM	Type: ______________________
Tone	□ AM	□ PM	Type: ______________________
Targeted Serums	□ AM	□ PM	Type: ______________________
Moisturize	□ AM	□ PM	Type: ______________________
Sunscreen	□ AM	□ PM	Type: ______________________
Retinol or Retinoic Acid	□ AM	□ PM	Type: ______________________
Other: ________________	□ AM	□ PM	Type: ______________________

Occasional Products:

Type: ______________________ Frequency: ______________________

Type: ______________________ Frequency: ______________________

Type: ______________________ Frequency: ______________________

To the best of my knowledge, the information on the form is accurate. I understand that providing false information can be dangerous to my health. It is my responsibility to inform Regen Rx of ***any*** changes to my medical history.

Signature: ______________________________ **Date**: ____________________

Reviewed by: ______________________________ **Date**: ____________________