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PATIENT QUESTIONNAIRE

Help us create a hyper-customized plan for you by completing the questions below.

Patient Details

Name: _____

Email: _____

Telephone: _____

What is your skin type? (Select One by marking with an **X**)

- [ ] Normal
- [ ] Dry
- [ ] Oily
- [ ] Sensitive
- [ ] Combination

My skin concerns are: (Choose as many as apply by marking with an **X**)

- [ ] Texture/Dullness
- [ ] Uneven complexion
- [ ] Fine lines/wrinkles
- [ ] Dark circles
- [ ] Redness/Rosacea
- [ ] Enlarged pores
- [ ] Aging: volume loss/laxity
- [ ] Eyes: lines/crepey skin
- [ ] Acne/breakouts
- [ ] Melasma/pregnancy mask
- [ ] Neck/décolleté

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My age group (Select One by marking with an **X**)

	Teens
	20'S
	30'S
	40'S
	50'S
	60'S +

On a scale of 1 to 10, how satisfied are you with your skin currently?
(Select One by marking with an **X**)

Very unhappy Very happy

1	2	3	4	5	6	7	8	9	10

From your selections, list your 3 desired outcomes, in order of priority.

1. _____
2. _____
3. _____

Do you have any medical conditions/illnesses?
Please list and explain, including medications.

_____
_____
_____
_____
_____
_____

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Lifestyle: (Choose as many as apply by marking with an **X**)

☐	Mainly indoors	☐	Live in the suburbs
☐	Mainly outdoors	☐	Shift worker
☐	Commute to work	☐	Insufficient sleep
☐	Ride train /subway	☐	Physically active
☐	Air travel often	☐	Stress
☐	Live in the city	☐	Smoker

How many glasses of water do you drink on a daily basis? (Select one by marking with **X**)

1	2	3	4	5	6	7	8	9	10

List any treatments you have had in the past.

_____
_____
_____
_____
_____

List any products you have used in the past. (Please include Retinols, AHA's, BHA's, if applicable.)

_____
_____
_____
_____
_____