Skin Health Questionnaire

Personal Information	
Name:	Date:
Address:	Cell phone:
City:	Zip code:
Email:	Date of birth:
Occupation:	Referred by:

Health	
Physician:	Smoke – Yes or No
Current Medications:	Pregnant – Yes or No
Allergies:	Prone to Cold Sores – Yes or No
Have you been treated for… (circle all that applies) Depression – Cancer – Skin Issues – High Blood Pressure – Diabetes – Acne – Heart Disease	Hormone Therapy – Yes or No If yes please explain:

Wellness	
Current level of Stress: (bad) 1 2 3 4 5 6 7 8 9 10 (good)	Exercise / how often:
How much water do you drink daily:	Use Tanning Beds – Yes or No
List Supplements / Vitamins:	Average Amount of Sleep:
When you go out into the sun do you … Always Burn (l) Usually Burn (ll) Sometimes Burn (lll) Rarely Burn (lV) Very Rarely Burn (V) Never Burn (Vl)	Date of Last Sun Burn:
Are you under a treatment plan of a … Dermatologist or Doctor or Plastic Surgeon or Esthetician	Date of Last Facial Treatment:

Skin Health	
Skin Concerns: (circle all that apply) • Dark Spots/Age Spots • Dry/Rough • Oily/Congested • Acne/Acne Prone • Skin Laxity/Saggy • Uneven Skin Pigmentation • Redness • Dark Circles • Eye Puffiness • Sensitive/Inflamed Skin	Home Care Routine:
Do you use daily SPF Sunscreen?	If Not, Why?
How do you feel about your overall quality of your skin … (bad) 1 2 3 4 5 6 7 8 9 10 (good)	Are you open to advanced treatments chemical peels or resurfacing treatments? Yes or No
Your Skin Type: (circle all that apply) • Normal • Dry/Dehydrated • Oily/Congested • Combination Skin • Sensitive Skin • Rosacea • Acne/Acne Prone • Scaly Skin / Irritated Skin	List Skin Care Products Used:
Treatment Wish List: • Wrinkle Lifts • Lightening Lifts • Acne Lifts • HIFU Lift & Tightening • Spot Lift & Removal Treatment	Please list any questions or concerns:

Thank you for completing the Skin Health Questionnaire

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Signature / Date