

Skin Care Questionnaire

Date: _____
Name: _____ Birthdate: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Referred by: _____

Personal Data

Smoker _____no _____yes pregnant _____no _____yes

Cosmetic surgery _____no _____yes, When _____

Describe _____

Medication _____no _____yes What kind? _____

Any health problems? _____no _____yes Explain _____

Any allergic reactions to medication? _____no _____yes

Describe _____

Do you have any allergies? _____no _____yes

Do you suntan? _____no _____yes

Do you use sunscreen? _____no _____yes

Please name the brand of products you are currently using:

Cleanser _____ Toner _____

Moisturizer _____ Scrub _____

Mask _____ Buff Puff _____

Other _____

Have you ever used Retin- A? _____no _____yes What strength? _____

Have you ever been treated with Phenol or Trichloroacetic acid? _____no _____yes

Have you ever used Hydroquinone? (Skin lightener) _____no _____yes

Have you ever been on Accutane? _____no _____yes When? _____

Have you ever had herpes, hives, cold sores, fever blisters, keloids? Circle if applies.

When? _____

Would you characterize your skin as: Sensitive _____ Rough _____

Dry _____ Oily _____

If you had a complaint about your skin what would it be? _____

Describe your skin in three words _____

Comments

Picture: