SkinCare Questionnaire

Name: _____
Nick Name: _____

Date of Birth: _____
Height: _____ Weight: _____

Health History

Allergies List all allergies or reactions to drugs, food, or environment:

_____

Medications List all prescription medications include contraceptives and hormones:

_____

List all over the counter medications (i.e. aspirin, sleeping pills, diet pills, herbal supplements, etc.):_____

Do you have any health problems or concerns? _____

_____

Could you be pregnant?	Yes_____ No_____	Do you smoke?	Yes _____No_____
Do you use alcohol?	Yes_____ No_____	Number of packs per day?	_____
How much and how often?	_____	Number of years?	_____
Do you wear contact lenses?	Yes_____ No_____		

Have you ever had herpes, hives, cold sores, fever blisters, or keloids? Yes_____ No_____ When_____
If so, are you being treated with anti-viral? _____

Have you had cosmetic surgery? Yes_____ No_____ When_____
Please describe: _____

HOW DID YOU FIND US? _____

Do you sunbathe; use tanning beds, or self-tanner? Yes_____ No_____ What type?_____
How often? _____

Skin and Products

Please list the name brand of the products you are currently using?

Cleanser	_____	Sunscreen	_____
Toner	_____	Scrub/Exfoliator	_____
Serum	_____	Mask	_____
Moisturizer	_____	Other	_____

Have you ever used the following?

Retin-A	Yes_____ No_____ Strength_____		Phenol or TCA	Yes_____ No _____Strength_____	
Hydroquinone	Yes_____ No_____ Strength_____		Accutane	Yes_____ No_____ When_____	

Would you characterize your skin as (please circle one) Sensitive Rough Dry Oily Combination

What would you like to see improve with your skin? _____

_____

The information I have provided above is accurate to the best of my knowledge.

Signature_____ **Date**_____