Skin Care Questionnaire

Date: ____________

Name: _____________________________  Birthdate: _______________

Address: ____________________________________________________________________

City: ______________  State: _____  Zip Code: ________

Phone: ______________  Email: ______________________________________

Referred By: _________________________________________________________________

Please check YES or NO to the following questions

• Smoker:  YES ___ NO ___
• Pregnant: YES ___ NO ___
• Cosmetic Surgery: YES ___ NO ___ If YES, when and what procedures:
__________________________________________________________________________

• Medication: YES ___ NO ___ If YES, what kind(s)?
__________________________________________________________________________

• Any health problems? YES ___ NO ___ If YES, please explain:
__________________________________________________________________________

• Any allergic reactions to medication? YES ___ NO ___ If YES, please describe:
__________________________________________________________________________

• Do you have any allergies? YES ___ NO ___ If YES, please explain:
__________________________________________________________________________

• Do you suntan? YES ___ NO ___
• Do you use sunscreen? YES ___ NO ___
• Have you ever used Retin-A? YES ___ NO ___ If YES, what strength? ______________________
• Have you ever been treated with Phenol or Trichloracetic acid? YES ___ NO ___
• Have you ever used Hydroquinone (skin lightener) YES ___ NO ___
• Have you ever been on Accutane? YES ___ NO ___ If YES, when? _________________________
• Have you ever had herpes, hives, cold sores, fever blisters, keloids? YES ___ NO ___ If YES, then when?
__________________________________________________________________________

• How would you characterize your skin? (Please check the one that applies)
Sensitive___  Rough ___  Dry ____  Oily/Acne-prone ___
• If you had one complaint about your skin, what would it be? __________________________
• Describe your skin in three words: _____________________________________________
• Additional comments/concerns:_______________________________________________

Please name the brand of products you are currently using

Cleanser: __________________  Toner: _____________  Mask: _________________

Moisturizer: _________________  Scrub: ______________  Other: ___________________