



# Skin Health Questionnaire

Client should complete the following, as directed, as thoroughly and in as much detail as possible.

Name		Date
Daytime Phone		Evening Phone
Street Address		City
State	Zip	Email
Birthdate	Emergency Contact	Relation to Contact
Your Physician		Phone Number
How did you hear about us?		Occupation

## INTEREST

Please indicate which services you are interested in:

<input type="checkbox"/> Skin Care Consultation/Advice	<input type="checkbox"/> Clinical Treatments	<input type="checkbox"/> Acne Treatment/
<input type="checkbox"/> Home Care Products	<input type="checkbox"/> Age Management	Management <input type="checkbox"/> Rosacea

What do you wish to change about your skin?

## Medical History

Are you currently, or have you previously experienced any of the following:

<input type="checkbox"/> Heart condition	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Herpes Simplex
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid condition	<input type="checkbox"/> Asthma	<input type="checkbox"/> AIDS/HIV Positive
<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Autoimmune
<input type="checkbox"/> Anemia	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Hypo/Hyper glycemia	Type _____
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Contact Lenses

If you are currently experiencing or being treated for any health-related condition, please describe:

Have you ever had surgical or non surgical procedure? If yes, where on your body was the surgery performed?

Do you have any allergies? Also list any skin treatment products you have used that caused an unexpected reaction or side-effect:

Please list all over-the-counter and prescription medications you are currently taking:

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Please indicate if you have ever used any of the following medications for skin treatment:

- |   |                                   |   |                                      |
|---|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Accutane         | <input type="checkbox"/> Retin A  | <input type="checkbox"/> Fosdex         | <input type="checkbox"/> Renova      |
| <input type="checkbox"/> Cortisone        | <input type="checkbox"/> Sulfer   | <input type="checkbox"/> Glycolic Acid  | <input type="checkbox"/> Clindamycin |
| <input type="checkbox"/> Staticin         | <input type="checkbox"/> DesquamX | <input type="checkbox"/> Salicylic Acid | <input type="checkbox"/> Tazoratene  |
| <input type="checkbox"/> Benzoyl Peroxide | <input type="checkbox"/> Zerac    | <input type="checkbox"/> Lactic Acid    | <input type="checkbox"/> Metrogel    |

What condition were you treating with this medication(s)?

When was the last time you used these medications?

### Women

Are you pregnant? Yes No

Are you planning a pregnancy in the near future? Yes No

Are you currently on any type of hormone therapy? If yes please describe:

Do you have regular periods? Yes No Are you going through menopause? Yes No

Do you have any hormone imbalance? Yes No

Have you undergone surgical menopause (hysterectomy) Yes No When?

### Skin Self-Analysis

What skin care products are you currently using?

Are you wearing a daily sunscreen? Type: SPF:

Is your skin:  Oily or acne prone?  Dry?  Normal?  Sensitive?

Have you ever treated or been treated for a skin condition? If yes, what condition?

How did you treat the condition:

Dermatologist  Aesthetician \*Self treated with products purchased from:  Drug Store  Department Store

Were you happy with the result? Yes No

Are you currently treating or being treated for any skin condition?

### Lifestyle and Stress Analysis

Do you come in contact with any chemicals at work? Do you work around excessive heat or cold?

Do you use Personal Protective Equipment (PPE\*)? If so, what type and for how long? \*Masks, gloves, shields, etc.

How often do you exercise? Average hours of sleep What is your stress level?

How many minutes a day are you exposed to sunlight? How many hours a week do you use a tanning bed?

Do you get cold sores? What is your ancestry? Father Mother

Please indicate any of the following that apply to your eating habits:

- |                                      |   |  |  |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Fast food   | <input type="checkbox"/> Salt your food | <input type="checkbox"/> Dairy products        | <input type="checkbox"/> Peanut Butter |
| <input type="checkbox"/> Baked Bread | <input type="checkbox"/> Seafood        | <input type="checkbox"/> Ethnic or Spicy foods | <input type="checkbox"/> Peanuts       |

How much water do you drink per day? Caffeine? Carbonated drinks?

Do you smoke tobacco products? Average alcohol consumption per week

Have you changed your brand of skin care products in the last year? If yes, why did you change?

**\*I understand and agree that I am ultimately responsible for payment in full for services received.**

Signature of Patient or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_