Skin Care and Health Questionnaire

Please read carefully and answer all confidential questions as best as you can so that we may have a better understanding of your general health and lifestyle, enabling us to accurately analyze and assess your needs.

GENERAL PATIENT/CLIENT INFORMATION	MEDICAL INFORMATION
Name	Under a Physician's care? ☐ NO ☐ YES
Date	List Surgeries
Date of Birth _____/_____/_____ Age	List Allergies/Sensitivities
Gender	**CIRCLE HEALTH CONDITIONS:**
Address Street	Cancer ☐ Diabetes ☐ Hormone ☐ Hypertension ☐ Stroke ☐
	Heart Disease ☐ Vascular Disorder ☐ Migraine ☐ Insomnia ☐ Depression ☐
	Anxiety/Phobias ☐ Cold Sores ☐ Acne ☐ Dermatitis ☐ Eczema ☐
Cell Phone	Psoriasis ☐ Rosacea ☐ Break Outs ☐ Blood Clots ☐ Chronic Pain ☐
Home Phone	**OTHER:**
Work Phone	Have you ever had a fainting episode? ___NO ___YES
Please circle above which phone number you prefer to be contacted	Do you have any of the following neurological disorders?
EMAIL	☐ Myasthnia Gravis ☐ ALS ☐ Eaton-Lambert Syndrome
Would you like to be on our e-mail list? Yes ☐ No ☐	Are you Pregnant? ☐ NO ☐ YES Are you trying to become Pregnant? ☐ NO ☐ YES
Occupation	Are you Lactating? ☐ NO ☐ YES
Whom can we thank for your referral?	Do you have any metal implants? ☐ NO ☐ YES Where?
	List Oral Medications
In case of Emergency please contact:	List Topical Medications
Name	
Phone	List Supplements
Relationship	
Family Practioner/Physician	Have you ever had Botox cosmetic injections? ☐ NO ☐ YES
Name	If yes, last treatment date and where?
Phone	
Address	Have you ever had Dermal Fillers in the past? ☐ NO ☐ YES
	If yes, last treatment date and where?

HEALTH/LIFESTYLE INFORMATION

Are you a smoker?	☐ No ☐ Yes
Do you exercise regularly?	☐ No ☐ Yes
Do you follow a restricted diet?	☐ No ☐ Yes
If yes explain	
Do you consume caffeine daily?	☐ No ☐ Yes
Do you consume alcohol weekly?	☐ No ☐ Yes
Do you drink less than 64oz. of water daily?	☐ No ☐ Yes
Rate your current stress level	☐ Low ☐ Moderate ☐ High
Do you get adequate sleep most nights?	☐ No ☐ Yes
Do you experience claustrophobia?	☐ No ☐ Yes
Do you sun bathe?	☐ No ☐ Yes
Do you use tanning beds?	☐ No ☐ Yes
Do you burn easily in moderate sun?	☐ Never ☐ Very Rare ☐ Rare ☐ Sometimes ☐ Usually ☐ Never
Do you exfoliate weekly?	☐ No ☐ Yes
Do you use sunscreen daily?	
Do you have any body piercings?	☐ No ☐ Yes
Do you wear contact lenses?	☐ No ☐ Yes
Do you have any tattoos?	☐ No ☐ Yes

SKIN INFORMATION

Rate your skin concerns from 1-10 (1 being most concerned and 10 being least)

☐ Acne ☐ Oily ☐ Dry ☐ Combination ☐ Normal ☐ Sensitive ☐ Dehydrated

☐ Red ☐ Hot ☐ Pigmented ☐ Itchy ☐ Large Pores ☐ Rough ☐ Scars

☐ Sun Damage ☐ Wrinkles ☐ Sagging ☐ Excess Hair

OTHER:

Circle if you use the following:

Cleanser ☐ Exfoliator ☐ Toner ☐ Serum ☐ Mas ☐ Moisturizer ☐ Sunscreen

Retinol ☐ Retin-A ☐ Differin/Adapalene ☐ HydroQuinone ☐ Hydrocortisone ☐

Metrogel ☐ Topical Antibiotic ☐ Cream/Gel Depilatory ☐

Do you have a history of skin cancer in your family? ☐ NO ☐ YES

Have you had the following procedures? ☐ NO ☐ YES **If yes, circle below**

☐ Chemical Peels ☐ Microdermabrasion ☐ Ultrasound ☐ Waxing
☐ Dermal Needle ☐ Derma Plane ☐ LED ☐ Laser Hair Removal

From 1-10 (1 being horrible, 10 being fantastic) Rate how you feel about your skin

What do you like about your skin?

I understand the informationI I have provided above is true and correct. I also understand that all information stated is strictly confidential and will not be shared with outside of this facility.

Signature_____ **Date:** _____

PROFESSIONAL USE ONLY ANALYSIS AND DISCOVERY NOTES:	Initials
MEDICAL	
LIFESTYLE	
SKIN	
HEALTH	