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SKIN CARE QUESTIONNAIRE

Name_____ Date _____

Address_____ City _____ ST_____ Zip_____

Home Phone _____ Work/Cell Phone_____

Date of Birth_____ Age_____ Sex _____

Referred By _____ Email:_____

PERSONAL DATA:
Please circle yes or no for the following questions.

Smoker: Yes or No

Cosmetic Surgery: Yes or No If Yes, when _____

Describe Procedure: _____

Are you under the care of a physician? Yes or No

Any health problems: Yes or No

Do you have any allergies: Yes or No If yes, please explain: _____
_____

Do you suntan: Yes or No

Do you use sunscreen: Yes or No

Please name the brand of products you are currently using:

Cleanser: _____ Toner: _____

Moisturizer: _____ Scrub: _____

Mask: _____ Buff Puff: _____

Other: _____

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Please circle no or yes to the following questions:

Have you ever used Retin-A? Yes or No
If yes, what strength? _____

Have you ever used Hydroquinone (skin lightener)? Yes or No
Have you ever been on Acutance? Yes or No
If yes, when? _____
Have you had herpes, hives, cold sores, fever blisters, or keloids? (Circle all that apply)
If yes, when? _____
How would you characterize your skin? (Circle one) Rough Dry Oily/Acne-prone
If you had on complaint about your skin, what would it be? _____

_____

Please check if you have or have had any of the following:

Diabetes _____
Hepatitis _____
Herpes _____
Menopause _____
Sensitive to Anesthetic _____
Lupus _____
Irregular Menses _____
Heart Problems _____
Hysterectomy _____
Hypertension _____
Photosensitive Disorder _____
Autoimmune Illness _____

If you answer yes to the following, please explain.

Skin cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 weeks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Areas of interest for aesthetic treatment: _____

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SKIN TYPE QUESTIONNAIRE

Circle the one that best describes you:

Genetic Disposition

Score	0	1	2	3	4
What are the color Of your eyes?	light blue, gray, green	Blue grey, green	Blue	Dark brown	Brownish black
What is the natural Color of your hair?	Sandy Red	Blonde	Chestnut/ Dark Blonde	Dark Brown	Black
What is the color of your skin (non-exposed areas)	Reddish	Very Pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles On unexposed areas?	Many	Several	Few	Incidental	None

Total Score for Genetic Disposition: _____

Tanning Habits

Score	0	1	2	3	4
When did you last exposure your body to the sun or artificial tanning	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always

Total Score for Tanning Habits: _____

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Reaction to Sun Exposure

Score	0	1	2	3	4
What Happens When you Stay in the	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
To what Degree do Brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark Brown Quickly
Do you turn Brown within Several hours after Sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your Face react to The sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total Score for Reaction to Sun Exposure: _____

Skin Type Score:	**Fitzpatrick Skin Type:**
I	
II	
III	
IV	
Over 31	V-VI

I attest that the above information is true and understand that my provider relies on this information to provide safe and effective treatment.

Patient Signature: _____ Date: _____