Skincare History Questionnaire

Patient Profile & Waiver

Last Name______________________________First___________________________Middle________________

Birthdate______________Address____

City__________________State_____Zip__________Cell #__________________Work Ph_________________

PATIENT PROFILE HISTOLOGY

Allergies: (Have you had an allergic reaction to any of the following?)

Aspirin	❑ Yes	❑ No	Grapes	❑ Yes	❑ No	Seeds	❑ Yes	❑ No
Salicylates	❑ Yes	❑ No	Pumpkin	❑ Yes	❑ No	Lecithin	❑ Yes	❑ No
Sulphur	❑ Yes	❑ No	Fish/marine/iodine	❑ Yes	❑ No	Roses	❑ Yes	❑ No
Milk	❑ Yes	❑ No	Latex	❑ Yes	❑ No	Ingredients in skincare		
Apples	❑ Yes	❑ No	Coconut	❑ Yes	❑ No	products	❑ Yes	❑ No
Citrus	❑ Yes	❑ No	Nuts	❑ Yes	❑ No	If yes, write allergies on this line		

____

Medications: (Complete all that applies)

Have you ever taken Accutane ❑Yes ❑No When?______________Dosage?________Months?_____________

Hepatitis? ❑Yes ❑No Have you used Tretinoin/Retin A? ❑Yes ❑No %_______ Last used? ____________

Treatment for herpes simplex? ❑Yes ❑No ❑Acyclovir ❑Zovirax ❑Valtrex ❑Abreva ❑Denavir

❑Birth control pills ❑Hormone Treatment ❑Breast feeding ❑Currently pregnant ❑Attempting pregnancy

❑Differin ❑Azelaic Acid ❑Tazorac ❑Triluma ❑Metrogel ❑Renova ❑Avita

❑Other medications____

HOME SKINCARE PRODUCTS

Cleanser________________________Times/day_________________Toner/Astringent____________________

Moisturizer______________________Eye cream_________________Exfoliants/Scrubs___________________

Sunscreen use___________________Other_____________________Make-up___________________________

EXPOSURE (Check all that have occurred **within the last 14 days**)

❑Sun ________________
❑Tanning Bed__________
❑Facial Surgery

❑Collagen
❑Fillers
❑Botox
❑Permanent Make-up
❑Extractions

❑Microdermabrasion
❑Dermabrasion
❑Chemical Exfoliation (Peels)
❑Hair Treatments (perm, color, etc.)
❑Lesion/Mole removal

❑CO2
❑Waxing
❑Laser Hair Removal
❑Light Treatment
❑Laser Resurfacing

❑Smoke…Quantity?______/day Alcohol consumption: ❑Yes ❑No

HEALTH & NUTRITION

❑Excellent ❑Good ❑Fair ❑Poor ❑______glasses of water/day ❑Vitamins ❑Supplements ❑Exercise

AREAS OF CONCERN

❑Lines/wrinkles ❑Uneven texture ❑Sagging/Jowling ❑Uneven tone ❑Psoriasis ❑Eczema ❑Dryness

❑Rosacea/Redness ❑Scarring ❑Acne ❑Broken capillaries ❑Keloids ❑Skin cancer ❑Oily ❑Pores

❑Hands ❑Chest ❑Lips ❑Eyes ❑Other areas ***OR*** **Hair Removal**:___________________________

FITZPATRICK SKIN ANALYSIS (see Fitzpatrick Skin Test form before completing)

Caucasian	I ❑	II ❑	III ❑	IV ❑	V ❑	VI❑	Indian	I ❑	II ❑	III ❑	IV ❑	V ❑	VI❑
African American	I ❑	II ❑	III ❑	IV ❑	V ❑	VI❑	Hispanic	I ❑	II ❑	III ❑	IV ❑	V ❑	VI❑
Asian	I ❑	II ❑	III ❑	IV ❑	V ❑	VI❑							

I authorize to receive product & service specials via email/mail to:_______________________________________

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge.

I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I understand that hair removal requires multiple treatments. Results vary depending on prescriptive medicines and individual condition(s) and may require more than 5 treatments. Package pricing includes 5 treatments only.

I understand that all sales are final as there is a **"NO REFUND"** policy on all products and services.

Client Signature:____Date:____________________

DO NOT COMPLETE BELOW THIS LINE

PATIENT SKIN ANALYSIS (DO NOT COMPLETE)

❑ Acne - Type:_______ ❑ Scars

❑ Comedones:_________________________________

❑ Enlarged pores:_____________________________

❑ Elastosis:__________________________________

❑ Keloids:___________________________________

❑ Keratosis:__________________________________

❑ Milia:_____________________________________

❑ Pigmentation:_______________________________

❑ Rosacea/Redness:____________________________

❑ Wrinkles ❑ Fine ❑ Deep:______________________

Photo taken ❑ Yes ❑ No

❑ Oily ❑ Dry ❑ Normal ❑ Combination

❑ Thick ❑ Thin ❑ Normal

HAIR REMOVAL:__________________

____

____

____

____

____

MAIN CONCERN:____

Recommended products/services:

____

____

____

____

____