

**SKIN CARE QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # / Unit #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Referred By: \_\_\_\_\_

**PERSONAL DATA**

Answer questions below by placing a **check in the appropriate column:**

- | <b>YES</b>               | <b>NO</b>                |                                       |                 |
|--------------------------|--------------------------|---------------------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?                     |                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke?                         |                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had cosmetic surgery?        | When: _____     |
|                          |                          | Describe the surgery:                 | _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any medication(s)?     | Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Any allergic reactions to medication? | Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies?            | Describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you suntan?                        |                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use sunscreen?                 |                 |

Please describe your skin care routine and products that you currently use:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                          |                          |   |             |
|--------------------------|--------------------------|---|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever used Retin-A?   | When: _____ |
|                          |                          | What strength:  | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated with Phenol or Trichloroacetic acid (TCA)?   |             |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever used Hydroquinone (Skin Lightener)?   |             |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been on Accutane?   | When: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had <input type="checkbox"/> herpes, <input type="checkbox"/> hives, <input type="checkbox"/> cold sores, <input type="checkbox"/> fever blisters, or <input type="checkbox"/> keloids? |             |

Would you characterize your skin as:

- Sensitive**    **Rough**    **Dry**    **Oily**

Describe your main concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_