



HEALTH AND SKIN CARE QUESTIONNAIRE

Today's Date: _____	Referred By: _____
Name: _____	Advertisement Seen: _____
Address: _____	Marital Status: _____
City: _____	Birth Date: _____
State, Zip: _____	Male: _____ Female: _____
SSN: _____	Occupation: _____
Home: _____	Insurance Co: _____
Work #: _____	
Cell #: _____	E-mail: _____
Emergency Contact: _____	Would you like to receive our Monthly
Emergency Phone #: _____	Specials via e-mail? Yes _____ No _____

Please identify any of the following health issues you currently have or have had in the past:

Acne	Yes	No	Hormone Imbalance	Yes	No	Previous Surgeries: (include tonsillectomy, wisdom teeth extraction, etc): _____ _____ _____ _____ _____
Asthma/Hay Fever	Yes	No	Metabolic Disorders	Yes	No	
Arthritis	Yes	No	Pace Maker	Yes	No	
Bleeding Tendencies	Yes	No	Defibrillator	Yes	No	
Blood Pressure High/Low	Yes	No	Phobias	Yes	No	
Cancer	Yes	No	Pregnant	Yes	No	
Cysts	Yes	No	Due Date: _____			
Diabetes	Yes	No	Nursing	Yes	No	
Eczema	Yes	No	Psoriasis	Yes	No	
Epilepsy/Seizures	Yes	No	Scarring	Yes	No	
Heart Problems	Yes	No	Thyroid	Yes	No	
Hepatitis/Jaundice	Yes	No	Other: _____			
HIV Exposure	Yes	No				

Oral Medications --
Prescription & Over The Counter (Ex: aspirin, herbal preparations, vitamins, etc.)

Topical Medications --
Prescription & Over the Counter

Allergies --
Medications, Foods, Ingredients, Environmental Substances

Circle your level of STRESS (1=low; 10=high) 1 2 3 4 5 6 7 8 9 10

Are you on a restricted DIET? YES NO

Do you have regular SLEEP patterns? YES NO

Do you have regular EXERCISE patterns? YES NO

Do you SMOKE? YES NO

What is your ALCOHOL consumption? NONE LOW MODERATE HIGH

What is your CAFFEINE consumption? NONE LOW MODERATE HIGH

How many eight ounce glasses of WATER do you drink per day? _____

Have you experienced any COSMETIC surgery? YES NO If so, when and what type?

Do you wear contact lenses? YES NO

Do you have issues with any of the following skin conditions? (Please check all that apply).

<input type="checkbox"/> Redness	<input type="checkbox"/> Age Spots	<input type="checkbox"/> Large Pores	<input type="checkbox"/> Scarring
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Whiteheads	<input type="checkbox"/> Warts
<input type="checkbox"/> Eczema	<input type="checkbox"/> Hypopigmentation	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Ingrown Hair
<input type="checkbox"/> Fine Lines	<input type="checkbox"/> Moles	<input type="checkbox"/> Acne/Breakouts	<input type="checkbox"/> Cellulite
<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Broken Capillaries	Where? _____	

How would you best describe your skin?

Oily Oily to Normal Normal Normal to Dry Dry

Identify the products you are CURRENTLY using to care for your skin. Please list brand name and type (sudsy, lathering, AHA, SPF#, etc.) for all that apply:

Cleanser(s) _____ Toner/Astringent _____ Moisturizer(s) _____
Masque(s) _____ Exfoliant/Scrub _____ Night Cream _____
Eye Cream _____ Sunscreen _____ Other _____

Identify the cosmetic products you are CURRENTLY using. Please list brand name and type (cream, liquid, pressed or loose powder, etc.) for all that apply.

Foundation _____ Powder _____ Blush _____
Eye Shadow _____ Mascara _____ Lip Color _____

Have you experienced any of the following treatments? (Please check all that apply).

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Aesthetics Facial | <input type="checkbox"/> AHA/BHA Peels | <input type="checkbox"/> Endermologie | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Jessner Peels | <input type="checkbox"/> Body Wraps | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Medical Microdermabrasion | <input type="checkbox"/> TCA Peels | <input type="checkbox"/> Massage | |
| <input type="checkbox"/> Makeup Makeover | <input type="checkbox"/> Deep Peels | <input type="checkbox"/> Lash/Brow Tints | |
| <input type="checkbox"/> Laser Hair Removal | | | |

Other Cosmetic Treatments: _____

Do you wear a SUN PROTECTANT on a daily basis? YES, SPF# _____ NO

Are you using or have you ever used any Renova, Retin-A, Alpha Hydroxy or Glycolic Acid topical product? NO YES Please specify strength of product and duration of use.

Are you using or have you ever used Accutane? NO YES Please specify duration of treatment. _____

Are you under going or have you ever had Radiation therapy? NO YES Please specify dates. _____

Do you have any implants, tattoos, or permanent makeup? NO YES Please specify type and location. _____

Conditions, treatments, procedures, and services we offer that may be of interest to you. Please check those you would like to have discussed with you.

- | | |
|---|--|
| <input type="checkbox"/> BOTOX (Botulinum Toxin Type A) | <input type="checkbox"/> SilkPeel: diamond tip with chemical infusion |
| <input type="checkbox"/> Filler Therapy: Restylane, Radiesse, Perlane
Juvederm Plus, Juvederm Ultra Plus, etc. | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Liposuction, Tumescence type | <input type="checkbox"/> Age spots/Liver spots/Birthmarks |
| <input type="checkbox"/> Thermage Skin Tightening for face and body | <input type="checkbox"/> Skin Care Products: Prescription and Physician strength |
| <input type="checkbox"/> Chemical Peels: TCA/Glycolic/Salicylic acid | <input type="checkbox"/> Skin Care and Sunscreen advice |
| <input type="checkbox"/> Acne: Advanced treatment with lasers | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Laser Skin Rejuvenation | <input type="checkbox"/> Excessive underarm perspiration (Hyperhidrosis) |
| <input type="checkbox"/> Facial Vein Treatment: laser | |
| <input type="checkbox"/> Spider Vein Treatment: laser, injections | |
| <input type="checkbox"/> Other, please specify: _____ | |

What concerns do you have about your skin and how would you like us to assist you?

