

Patient Information

Date: _____

Email Address: _____

Referred By: _____

Patient's Name: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work: _____ Cell: _____

Employer: _____ Occupation: _____

Sex: Male Female

DOB: ____/____/____

Age: _____

Questionnaire

1. Are you presently under the care of a dermatologist for your skin? Yes___ No___
2. Are you currently taking: Diuretics ___ Allergy Medications ___ Hormones ___
Birth Control ___ any other prescription or over the counter medication ___
If yes, please list all oral medications you are taking _____

3. List any topical skin medications (prescription or over the counter) you use or have
used: Acne ___ Retin-A ___ Glycolic Acid ___ Other _____
4. Do you take vitamins or food supplements? Yes ___ No ___ If yes, please list: _____

5. Have you ever taken Acutance? _____ When? _____ How Long? _____
6. Do you currently take Cumadin or Aspirin? Yes ___ No ___
7. Do you have any medication allergies? Yes___ No ___ List: _____
8. Do you have a history of Chronic Acne ___ Skin Sensitivity ___ Please Explain: _____

9. Have you ever had an adverse reaction after using a skin care regimen? Yes ___ No ___
If yes, please describe: (rash, irritation, peeling, sensitivity, etc.) _____

10. Are you pregnant or lactating? Yes ___ No ___

11. Do you have regular periods? _____ Are you going thru Menopause? _____
12. During pregnancy, did you get hyperpigmentation or masking? _____
13. Do you smoke? Yes ___ No ___ If yes, how much: _____
14. Do you consume alcohol? Yes ___ No ___ If yes, how much: _____
15. Do you exercise? Yes ___ No ___ If yes, how much: _____
16. How do tan? Burn ___ Usually Burn ___ Sometimes Burn ___ Rarely Burn ___
Never burn - brown ___ Never burn - black ___
17. Does your skin ever flake or feel tight or dry? Yes ___ No ___
18. Is your skin shiny a few hours after cleansing? Yes ___ No ___ Sometimes ___
19. How often do you experience outbreaks? _____
20. Would you consider your skin: Dry ___ Combination ___ Oily ___ Acne Prone ___
21. Does your skin appear fragile or burn easily? Yes ___ No ___
22. Do you form thick or raised scarring from a cut or burn? Yes ___ No ___
23. Do you wax or use depilatories on your face? Yes ___ No ___ Identify: _____
24. Do you have a history of cold sores? Yes ___ No ___ Frequency: _____
25. Have you had any active lesions in the last 4-6 weeks? _____
26. Have you ever had chemotherapy or radiation? Yes ___ No ___ If yes, please
Explain: _____
27. Have you had facial surgery, facial peels, laser surgery or dermabrasion?
Yes ___ No ___ If yes, please explain: _____
28. Have you or any member of your family had skin cancer? Yes ___ No ___
29. Are you active outdoors? _____ Explain: _____
30. Do you use daily sun protection? Yes ___ No ___ SPF _____
31. Are you currently using a tanning bed? Yes ___ No ___
32. Would you say your pain threshold is: Low ___ Medium ___ High ___
33. Do you wear contact lenses? Yes ___ No ___
34. I certify that I am not HIV positive, have Aids or Hepatitis C. (Initial Please) _____
35. What products are you using for your daily skin care? (Please list) _____

36. I hope to achieve the following results from treatments: _____

Signature: _____ Date: _____