



### Skin Care Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WHICH CONDITIONS DO YOU WANT TO IMPROVE? (Please x all that apply)**

- Hyper pigmentation (Brown Spots)     Acne/Acne Scarring     Sun Damage
- Enlarged Pores     Fine Lines & Wrinkles     Age Spots     Surgical Facial Scars
- Other: \_\_\_\_\_

**PLEASE CHECK IF PRESENTLY USING ANY OF THE FOLLOWING**

- Accutane     Topical Vitamin C     Obagi Nuderm System     Hydroquinone
- Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin, Tazoroc
- Glycolic Acid/Alpha Hydroxy Acid

**HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY SKIN PRODUCTS, LATEX, COSMETICS OR MEDICATIONS?**

- Yes     No    If Yes, Please explain:

**FEMALE CLIENTS**

- Are you on hormone replacement therapy?     Yes     No
- Are you presently taking birth control pills?     Yes     No
- Are you pregnant or planning to be?     Yes     No

**ALL CLIENTS**

- Do you use a sunscreen/sun block?     Yes     No
  - Do you have or have ever had acne?     Yes     No
  - Are you currently under a doctor's care?     Yes     No
  - Have you ever been treated with Zovirax or any medications for Herpes?     Yes     No
  - Do you have Epilepsy or Diabetes?     Yes     No
- If yes, you will be treated only with a doctor's release.*

**HAVE YOU HAD ANY OF THE FOLLOWING? (Please x all that apply)**

- Cosmetic Surgery     Botox Injections     Skin Cancer     Dermatitis     Keloid Scarring
- Laser resurfacing     Chemical Peels     Hepatitis     Other (Specify) \_\_\_\_\_

Do you smoke?  Yes  No

Do you take nutrient supplements?  Yes  No

Are you on a diet?  Yes  No

Do you exercise?  Yes  No

Do you wear contact lenses?  Yes  No

Have you had electrolysis or waxing in the past week?  Yes  No

Have you had permanent cosmetics?  Yes  No

If yes, where? \_\_\_\_\_

What skin care products are you currently using?

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Is there any other information I should know before beginning your treatment?

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**Client Signature** \_\_\_\_\_