Face & Eye
AESTHETIC CENTER

Skin Questionnaire

Name: _____ Today's Date:_____

Home Phone: _____ Cell Phone:_____

Address: _____City:_____ State:_____ Zip:_____

E-Mail Address: _____ Date of Birth:_____

How were you referred to us?_____

Do you have **any** allergies or skin sensitivities?

□**Yes** □**No** If yes, please list all_____

Do you currently take any oral medications? (includes oral hormones, birth control, antibiotics, tranquilizers, diuretics, etc)

□**Yes** □**No** If yes, list oral medications _____

Do you use any topical medications (includes Retin-A/retinols, Accutane, Hydroquinone, Benzoyl Peroxide, antibiotics, Metrogel, Efudex, cortisone, etc)? □**Yes** □**No** If yes, list topical medications _____

Have you **ever** had a cold sore? □**Yes** □**No** If yes, when was your last cold sore? _____

Do you use depilatories or wax on your face? □**Yes** □**No** If yes, when was the last time used?_____

Women only: Are you trying to become pregnant? □**Yes** □**No**

Are you pregnant or lactating? □**Yes** □**No**

Have you ever been pregnant? □**Yes** □**No**

During your pregnancy did you ever experience hyperpigmentation or "pregnancy mask"? □**Yes** □**No**

Do you currently use skincare products as a daily regimen? □**Yes** □**No**

If yes, list products_____

Have you previously had any of the following treatments/procedures?

Microdermabrasion □**Yes** □**No** Chemical Peels □**Yes** □**No** Permanent Cosmetics □**Yes** □**No**

Laser Resurfacing □**Yes** □**No** Botox/fillers □**Yes** □**No** Facial Surgery □**Yes** □**No**

Other procedures? _____

Do you use a sunscreen daily? □**Yes** □**No** Do you ever use tanning beds? □**Yes** □**No**

How does your skin react to sun exposure?

□**Always Burn** □**Usually Burn** □**Sometimes Burn** □**Rarely Burn** □**Never Burn "Brown or black skin"**

Is your skin pigmentation: □**Even** □**Uneven** □**Birthmarks** □**Pregnancy Mask**

What is your ethnicity and race? _____

What is your skin type? □ **Oily/Acne prone** □ **Dry** □ **Normal** □ **Combination**

How do you want to improve your skin/what are your concerns? _____

_____

_____

Patient Signature_____ Date_____

Technician Signature_____ Date_____