



CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Permission to send monthly newsletter with skin care tips and program updates? Yes _____ No _____
 (your email address will not be shared)

MEDICATIONS

| Medication | When | How Long | Medication | When | How Long |
|------------------|------|----------|-------------------|------|----------|
| Antibiotics | | | Androstendione | | |
| Accutane | | | Testosterone | | |
| Benzoyl Peroxide | | | Progesterone | | |
| Retin A | | | Thyroid | | |
| Cream or Gel? | | | Gonadotrophin | | |
| Tazorac | | | Danzol | | |
| Differin | | | Cyclosporin | | |
| Azelex | | | Lithium | | |
| Avita | | | Isoniazid | | |
| Cleocin-T | | | Immuran | | |
| E-mycin-T | | | Disulfuram | | |
| Copaxone | | | Dilantin/Tegretol | | |
| Corticosteroids | | | Steroids | | |
| Quinine | | | Marijuana | | |
| Other Meds | | | Cocaine/Speed | | |

MEDICAL HISTORY – please check all that apply ✓

| | | | | | |
|----------------|--|--------------------|--|---------------------|--|
| Herpes Simplex | | HIV/AIDS | | Hemophilia | |
| Eczema | | Thyroid Problems | | Lupus | |
| Psoriasis | | Hormone Problems | | Anemia | |
| Hepatitis | | Hysterectomy | | High Blood Pressure | |
| Cancer | | Ovary(ies) Removed | | Diabetes | |

| | | | |
|----------------------|-----------|--------------------|--|
| Staph Infection/MRSA | Pacemaker | Metal Pins in Body | |
|----------------------|-----------|--------------------|--|

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care? Yes No

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

- Have you ever had any reaction to any products or anything you have put on your face? Yes No
If yes, what products? _____
- Please check any of these you are allergic to: Sulfur Aspirin Latex
List any other allergies you know of: _____
- Do you smoke? Yes No
- Do you use fabric softener or fabric softener sheets in the dryer? Yes No
- Do you swim in a chlorinated pool? Yes No
- Do you work around chemicals, tars, oils, grease or inks? Yes No
- Occupation: _____ Do you work nights? Yes No
- Are you currently under a lot of stress? Yes No (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
- Women:** Do you use birth control pills, shots or use an IUD? Yes No
If so, which do you use? _____ What brand of pill? _____
Are you pregnant or nursing? Yes No
- Men:** Do you have shaving irritation? Yes No
What do you use for shaving? _____
- Diet – do you consume the following?

| Foods | ✓ | How often per week | Foods | ✓ | How often per week |
|---------------------|---|--------------------|------------------|---|--------------------|
| Fast Food | | | Peanuts | | |
| Processed Food | | | Sushi | | |
| Salty Snacks | | | Kelp and Seaweed | | |
| Milk/Yogurt | | | Miso Soup | | |
| Cheese | | | Soy | | |
| Whey or Soy Protein | | | Vitamins | | |
| Peanut Butter | | | Seafood | | |

PRODUCTS CURRENTLY USING – Provide product names.

| | |
|----------|--|
| Cleanser | |
| Toner | |

| | |
|-----------------------------|--|
| Serums | |
| Moisturizers | |
| Sun Screen | |
| Mask | |
| Foundation | |
| Blush | |
| Exfoliant (acids or scrubs) | |
| Acne Medications | |
| Anything Else? | |

OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

| Glycolic/Lactic/Mandelic Peels | When? | Where? |
|--------------------------------|-------|--------|
| Other Chemical Peels | | |
| If so, what kind: | | |
| Microdermabrasion | | |
| Dermabrasion | | |
| Laser Hair Removal | | |
| Laser Rejuvenation/Resurfacing | | |
| Skin Cancer Removal | | |
| Facial Waxing | | |
| Electrolysis | | |
| Other: | | |

How did you hear about us? _____