



Confidential Skin Health Questionnaire

(please print)

Today's Date ____/____/____

First Name _____ Last Name _____ DOB ____/____/____ Sex _____

Address _____ City _____

State _____ Zip _____ Phone – Home () _____ Work/Mobile () _____

E-mail _____ Best way to contact you: _____

Emergency Contact _____ Phone () _____

Dermatologist _____ Phone () _____

Primary Care Physician _____ Phone () _____

Is your occupation Outdoors Indoors

What is the reason for your visit today? _____

What special areas of concern do you have? _____

How did you hear about us? _____

Expectations and Health History

1. Are you pregnant, trying to become pregnant or lactating? If so, some treatments are not appropriate. Yes No

2. Do you wear contact lenses? Yes No

3. Do you have permanent makeup? Yes No Area(s)? _____

4. Do you currently have a sunburn/windburn/red face? Yes No If so, why? _____

5. Are you in the habit of going to tanning booths? Yes No Last visit? _____

6. Do you currently use or receive depilatories or waxing? Yes No Last time? _____

7. Are you applying any topical medications at this time? Yes No

Which? Hydroquinone Alpha Hydroxy Acids Other _____

8. Are you currently using any topical Retinoid prescription? (Retin-A®/Renova®/Differin®/Tazorax®/Avage®)

Yes No What strength? _____ For how long? _____

9. Have you taken Accutane® in the past 6 months? Yes No How long? _____

10. Have you had a chemical peel within the last 14 days? Yes No

11. Have you ever had a facial treatment in the past? Yes No Experience: _____

Facial surgery? Yes No Describe _____ How long ago? _____

Laser resurfacing? Yes No What kind? _____ When? _____

12. Are you under treatment for any current skin condition? Yes No If yes, what? _____

13. Do you have regular collagen, Botox® or other dermal filler injections? Yes No
14. Does your skin heal fast? Yes No Scar easily? Yes No
15. Do you bruise easily? Yes No
16. How would you describe your overall health? Excellent Good Fair Poor
17. Any personal or family history of skin cancer? Yes No

Provide detail _____

18. Do you have liver disease or impaired liver function? Yes No Detail _____

19. Do you have a history of cold sores or fever blisters? Yes No Last breakout? _____

20. Have you been told you may have psoriasis, eczema, acne, rosacea, healing problems (e.g. keloids)?

Yes No Which? _____

21. Are you allergic/sensitive to? (Check all that apply) None Milk Apples Citrus Grapes
 Latex Aspirin Perfumes Aloe Vera Hydroquinone Mushrooms Alcohol-based products

List any other allergies? _____

22. Have you ever used any other products that caused a bad reaction? Yes No

Describe _____

23. Are you taking any medications/vitamins/supplements at this time? (Antibiotics may increase sensitivity.)

Yes No Please list: _____

24. What is your hereditary background? _____

Natural eye color? _____ Natural hair color? _____

25. Describe your skin (Check all that apply)

- Normal Dry Oily T-Zone/Combination Sensitive Sun damaged Resilient
 Thick Thin Saggy Firm Acne Milia Comedones/Blackheads Cysts
 Breakouts Acne-scarred Large pores Small pores Rosacea Eczema
 Freckled Uneven/blotchy Mature Dehydrated Hyperpigmentation Hypopigmentation
 Asphyxiated Broken surface capillaries Fine lines/wrinkles Stretch marks
 Surgical/facial scars Flaky Tight Red Other _____

26. Which conditions would you like to improve? _____

27. How would you rate your skin? (Circle one)

- | | |
|---|--|
| I Always burns, never tans | IV Seldom burns – tans more than average |
| II Usually burns, tans less than average | V Rarely burns – tans profusely |
| III Burns moderately – tans about average | VI Never burns – deeply pigmented |

28. What is your present skincare regimen as well as the products you are using?

- | | |
|--|--|
| <input type="radio"/> Soap & water _____ | <input type="radio"/> Cleanser _____ |
| <input type="radio"/> Toner _____ | <input type="radio"/> Exfoliator _____ |
| <input type="radio"/> Moisturizer _____ | <input type="radio"/> Sunscreen _____ |
| <input type="radio"/> Mask _____ | <input type="radio"/> Serums _____ |

Other _____

Other _____

29. Our skin care specialists may want to recommend alterations or additions to your home care regimen; and, if necessary, refer you to a physician in order to achieve your skin improvement goals. Would that be OK with you? Yes No

Lifestyle & Diet

1. Do you wear sunscreen everyday? Yes No
2. Are you willing to wear sunscreen everyday? Yes No
3. Is your stress level: High Medium Low
4. Do you normally sleep well? Yes No
5. Do you regularly exercise? Yes No Type? _____
6. For women, oral contraceptives? Yes No
7. Do you smoke or use tobacco? Yes No
8. Alcohol Use? Yes (drinks/week: _____) No
9. Recreational drug use? Yes No
10. Do you have food intolerances? Yes No What? _____
11. Do you follow any special diet? Yes No What? _____
12. How many glasses of water do you consume daily? _____
13. How many cups of caffeinated beverage do you consume daily? 1-3cups 4 or more

Informed Consent Release

I _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care specialist will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will consult with my skin care specialist immediately.

I release and hold harmless my skin care specialist, The Skin Clinic of Virginia LLC, and all staff from any liability for adverse reactions that may result from this treatment.

I have read and understood all the foregoing information _____ Date _____

Client Signature

