

**Confidential Skin Health Questionnaire**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Family Physician \_\_\_\_\_

Email \_\_\_\_\_ Reason For Today's Visit \_\_\_\_\_

In order of importance, please rank the following concerns from, 1 (most important) to 5 (least important)

Reduction of Fine Lines  Reduction of Brown Spots/Sun Damage  Reduction of Redness

Reduction of Oil/Acne  Acne Scars Diminished

How would you describe your skin? (check all that apply)

Normal  Oily  Dry  T-zone/Combination  Sun-Damaged  Lax  Fine Lines  Wrinkles

Uneven  Large Pores  Acne  Acne Scarred  Sensitive  Rosacea

Do you wear contact lenses? \_\_\_\_\_

Are you pregnant?  Trying to get pregnant?

Are you a smoker?  How often do you consume alcohol? \_\_\_\_\_ Drink caffeine-type beverages? \_\_\_\_\_

How many ounces of water do you drink daily?  Do you take supplements/vitamins? \_\_\_\_\_

Do you have a history of herpes simplex virus (cold sores) ?  Last occurrence? \_\_\_\_\_

Have you had Botox or any other filler?  When? \_\_\_\_\_

Have you ever taken Accutane?  When?  Are you currently using Renova, Differin or Tretinoin?

Have you ever been under the care of a dermatologist, plastic surgeon or esthetician? \_\_\_\_\_

When you go out into the sun, do you (check one):

Always Burn(I)  Usually Burn(II)  Sometimes Burn(III)  Rarely Burn(IV)  Very Rarely Burns(V)  Never

Burn(VI) Do you sunbathe? \_\_\_\_\_ Use tanning beds?  How Often? \_\_\_\_\_

What skincare line/products are you currently using? \_\_\_\_\_ Do you use sun protection daily?

Please list all ALLERGIES including LATEX:

\_\_\_\_\_

Please list all MEDICATIONS you are currently taking (be sure to include any of the following: birth control pills, aspirin or ibuprofen, Coumadin or any blood thinning medications)

\_\_\_\_\_