Skin Care Questionnaire

Patient: _____ Date of Birth: ___/___/___

Today's Date: ___/___/___

Phone: _____ Email: _____

Address: _____

Do you sun tan?	❑ Yes ❑ No	Do you use a tanning bed?	❑ Yes ❑ No
Do you use DAILY sunscreen?	❑ Yes ❑ No	Do you use Retin-A type products?	❑ Yes ❑ No
Do you use a skin lightener?	❑ Yes ❑ No	Have you ever used Isotretinoin?	❑ Yes ❑ No
Have you been diagnosed with Rosacea?	❑ Yes ❑ No	History of cold sores?	❑ Yes ❑ No

Have you ever had peels/laser/botox/fillers/thermage/coolsculpting/PDT before? ❑ Yes ❑ No
If yes, when and describe?

_____

How many treatments? _____

If Yes, were you happy with the results? ❑ Yes ❑ No If no, why? _____

Would you characterize your skin as: ❑ Sensitive ❑ Dry ❑ Rough ❑ Oily

If you had a complaint about your skin, what would it be? _____

_____

Describe your current skin care regime in detail: Cleanser: _____

A.M. _____

P.M. _____

How did you hear about our office? _____

Do you desire information on other cosmetic services we provide? (Please Circle any areas of interest)

Botox **Laser Hair Removal** **Leg Veins** **Dermal Fillers**

Laser (for facial redness, blood vessels and sunspots) **Scar Treatments**

Body Contouring

Coolsculpting **PDT (Photodynamic Therapy)** **Thermage**

Chemical Peels **Laser Resurfacing** **Latisse** **Skin Care Routine**

Other_____