CLIENT QUESTIONNAIRE

Name: _____ Age: _____ DOB: ____/____/_____

Address: _____ City: _____ State: ____ Zip: _____

Work Phone: (_____) _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

I. Prescribed, over-the-counter and recreational drugs/medications: (past and present)

Medication	When	How Long	Medication	When	How Long
Antibiotics			Testosterone		
Accutane			Progesterone		
Benzoyl Peroxide			Disufuram		
Cleocin-T			Cyclosporin		
E-mycin-T			Dilantin		
Rein A Cream or Gel			Thyroid Medication		
Tazorac			Lithium		
Differin			Quinine		
Azelex			Isoniazid		
Sulphur			Immuran		
Avita			Danzol		
Androstendione			Gonadotrophin		
Cortisone			Steroids		
Minosine			Marijuana		
Copazone			Cocaine/Speed		

II. What else have you done for your skin:

Service	When	Service	When
Glycolic Acid Peels		Skin Cancer Removal	
Microdermabrasion		Facial Waxing	
Chemical Peels		Electrolysis	
Dermabrasion		Laser Hair Removal	
Plastic Surgery		Other:	

III. Products you are currently using: (please list product names)

Cleanser:
Toner:
Serums
Moisturizers:
SPF:
Mask:
Foundation:
Blush:
Exfoliant (ex: Glycolic):
Acne Medications:

IV. Lifestyle considerations:

1. Have you ever had **any** reactions to any of the above products or anything you have ever put on your face? Yes ☐ No ☐ If yes, which product(s): _____
   Describe your reaction: _____

2. Please place a check if you are allergic to: Sulphur ☐ Asprin ☐ Latex ☐

3. Do you Smoke? Yes ☐ No ☐

4. Do you use fabric softener or fabric softener sheets in the dryer? Yes ☐ No ☐

5. Do you pick at your skin? Yes ☐ No ☐

6. Do you work around chemicals, tars, oils or inks? Yes ☐ No ☐

7. Are you currently under a lot of stress? Yes ☐ No ☐

8. Please place a check if you regularly eat or ingest:
   Kelp ☐ Seaweed ☐ Sushi ☐ Salt ☐ Fast Foods ☐

9. WOMEN ONLY: Are you on birth control pills? Yes ☐ No ☐ If yes, which brand: _____
   Are you taking Dep Provera shots? Yes ☐ No ☐
   Are you pregnant or nursing? Yes ☐ No ☐

V. Skin care concerns: (please check all that apply)

Blackheads	☐	Dehydrated Skin	☐	Dry, Flaky Skin	☐
Whiteheads	☐	Dark Spots	☐	Sensitive Skin	☐
Pimples/Pustules	☐	Age Spots	☐	Razor Bumps	☐
Cysts	☐	Broken Capillaries	☐	Shaving Irritation	☐
Oily Skin	☐	Fine Lines/Wrinkles	☐	Acne Rosacea	☐

VI. Describe your skin type:

Oily ☐
Normal ☐
Dry ☐
Oily/Dry ☐
Sensitive ☐

VII: Medical History: (please check all that apply)

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

Are you under a dermatologist's care? Yes ☐ No ☐ If yes, name of doctor: _____

VIII: Miscellaneous:

1. Occupation: _____

2. How did you hear about us: _____