CLIENT SKIN CARE QUESTIONNAIRE

NAME: ___________________________ DATE: ___________________________

How did you learn about our skin care services? ____________________________________________________________

SKIN MANAGEMENT

1. What would you like to change about your skin? __________________________________________________________

2. What skin care products are you using currently? List below -
_____________________________________________________________________________________________
_____________________________________________________________________________________________

3. What results are you experiencing with these products? ____________________________________________________

4. Have you ever consulted with a physician for your skin? □ Yes □ No If yes, please answer the following -
   a. Physician’s Name: ___________________________
   b. What condition was treated? ___________________________
   c. Have you ever taken Accutane? □ Yes □ No From:______________ To:______________
   d. What other medications and treatments have you used?
      Medications: ___________________________
      Dates Used: ___________________________
      Results: ___________________________
      ___________________________
      ___________________________
      ___________________________

5. Do you ever get cold sores? □ Yes □ No

6. Have you ever had a skin sensitivity or allergy? □ Yes □ No If yes, please give more information below -
   Description of the Skin Irritant: ___________________________
   Describe the Reaction: ___________________________

7. Have you previously had any of the following?
   Chemical Peel: □ Yes □ No Date: ___________________________
   Laser Resurfacing: □ Yes □ No Date: ___________________________
   Facial Surgery: □ Yes □ No Date: ___________________________

SKIN CONDITION

1. Do you experience facial blemishes? Mark all that pertain and provide information on how often -
   Pimples: ______ How Often: ____________ White Heads: ______ How Often: ____________
   Cysts: ______ How Often: ____________ Acne Scars: ______ How Often: ____________

2. Have you ever had pigmentation of the skin during pregnancy or while on medications? □ Yes □ No

LIFESTYLE

1. What is your stress level? High: ____ Moderate: ____ Low: ____

2. Do you work outdoors, or spend significant time in the sun? □ Yes □ No

3. Do you use a sunblock when outdoors? □ Yes □ No

FEMALE CLIENT/HORMONES

1. Are you currently taking hormones? Oral Contraceptives: □ Yes □ No Estrogen/Progesterone: □ Yes □ No

2. Are you pregnant or lactating? □ Yes □ No

Client Signature: ___________________________ Date: ___________________________

Skin Care Specialist Signature: ___________________________ Date: ___________________________