

Skincare History Questionnaire

Name: _____ Date: _____

Email address: _____

Reason for your consult today? (i.e. product information, unwanted hair, make-up, Botox, Fillers, general skin care, acne, etc)

Are you presently under the care of a Physician? Yes ___ No ___ If yes please indicate why? _____

Do you smoke? Yes ___ No ___ Have you ever suffered from cold sores? Yes ___ No ___

Have you seen a dermatologist in the last 12 months? Yes ___ No ___

If yes, please circle which dermatologist you see: Dr. Silver Dr. Dalton Dr. Johnson Dr. Singh-Behl Dr. Konanahalli other _____

Do you have any history of skin cancer? Yes ___ No ___

Current medications: _____

Do you have any allergies or sensitivities? Yes ___ No ___ Please list: _____

Have you had any adverse reactions to any cosmetic procedures? Yes ___ No ___ Reaction: _____

Have you ever been diagnosed with Hepatitis? Yes ___ No ___ HIV/AIDS Yes ___ No ___

Skin Care Questions

Are you currently receiving any type of skin treatments? Yes ___ No ___ (please list) _____

Please detail your current skin care routine. Be as specific as possible. Include name of product or products.

A.M: What do you wash with? _____ What do you moisturize with? _____

Do you wear make up? Yes ___ No ___ Does it contain sunscreen? Yes ___ No ___ Level of SPF ___

Do you use a daily SPF? Yes ___ No ___ Additional Products used in a.m. (please list) _____

P.M. What do you wash with? _____ What do you moisturize with? _____

Additional products used in the p.m. (please list) _____

Which of the following best describes your skin? Circle all that apply:

Normal Dry Oily Combination AcneProne Melasma Rosacea Eczema Psoriasis

Have you had any cosmetic treatments with the following products or procedures?

Botox ___ Dysport ___ Restylane ___ Perlane ___ Juvederm ___ Radiesse ___

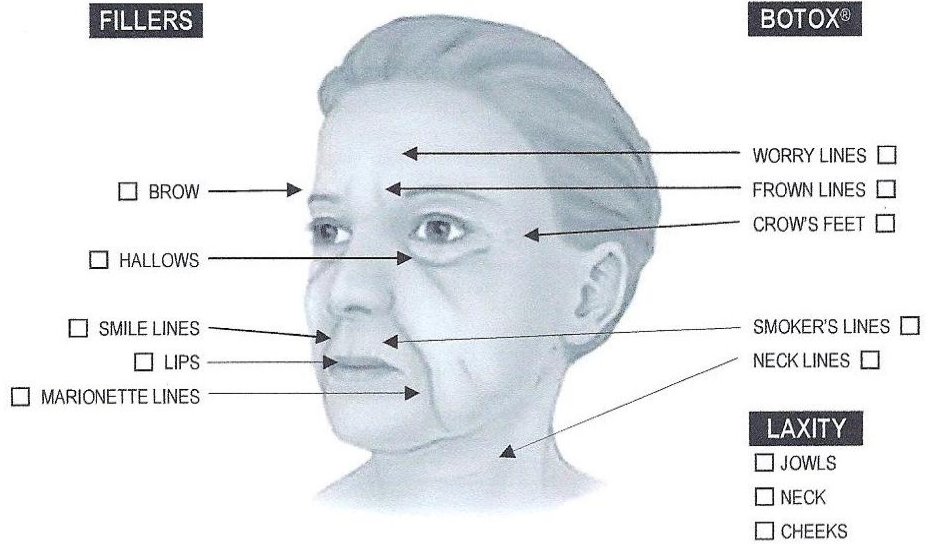
Cosmetic Tattooing ___ Laser Hair Removal ___ Facial Resurfacing ___ Facelift ___ Chemical Peels ___

Light Treatments/IPL/Fotofacial for uneven pigmentation ___ other: _____

Your Aesthetic & Skin Concerns:

Please review the list below and CHECK off the areas you have concerns and/or questions about.

- Brown Spots
- Redness
- Skin Laxity
- Texture
- Scarring
- Dark Circles
- Pores
- Veins
- Firmness
- Body Contouring
- Acne
- Unwanted Hair



Please feel free to elaborate: _____

Skin Type: when exposed to the sun without protection for about 1 hour you:

- _____ Always burn, never tan Type I
- _____ Almost always burn, sometimes tan Type II
- _____ Sometimes burn, sometimes tan Type III
- _____ Always tan (American Indian) Type IV
- _____ Are Hispanic, Asian, Mediterranean, Middle Eastern Type V
- _____ Are Black (African descent) Type VI

IF YOU ARE HERE FOR LASER HAIR REMOVAL PLEASE COMPLETE THE FOLLOWING:

I am interested in having permanent hair reduction for: (please circle all that apply)

Upper Lip Chin Bikini Underarms Abdomen Legs Hands Forearms Neck Back Other _____

What method of hair removal are you currently using? Shaving Tweezing Waxing Threading Electrolysis Laser IPL other _____

When is the last time you removed the hair you are interested in treating with laser? _____

What color do you consider the hair to be that you would like to treat? Black Brown Red Dark Blond Light Blond Gray White

Signature: _____

Date: _____