



## Skin Care History Questionnaire and Waiver

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Have you seen a dermatologist in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes list dermatologist name and reason for visit \_\_\_\_\_

Are you presently under a Physician's care? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes list physician's name and reason for visit \_\_\_\_\_

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, please list

Please circle the following conditions you have or had experience:

Hypertension	metal plate	diabetes	fainting
Hernia	stroke	contact lenses	anemia
Irregular pulse	claustrophobia	blood disorders	cancer
High cholesterol	varicose veins	seizures	eating disorders
Blood disorders	heart attack	epilepsy	headaches
Asthma	hepatitis	high/low blood pressure	tooth fillings
Cold sores	lupus	thyroid disease	

Do you take nutritional supplements? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a tendency to scar? Yes \_\_\_\_\_ No \_\_\_\_\_

**Allergies**

Have you ever had an allergic reaction to any of the following?

- \_\_\_\_\_ Aspirin or Salicylates
- \_\_\_\_\_ Grapes
- \_\_\_\_\_ Milk Products
- \_\_\_\_\_ Latex
- \_\_\_\_\_ Fish, marine or iodine
- \_\_\_\_\_ Skin care Products
- \_\_\_\_\_ Apples

Have you ever had Herpes Simplex? \_\_\_\_\_  
If yes have you been treated with Denavir® (Penciclovir), Zovirax® (Acyclovir) or Abreva?

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Are you being treated for Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_

**Female Clients Only:**

Are you on hormone replacement therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you presently taking birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you pregnant or nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently having skin care treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of treatment \_\_\_\_\_

Have you had any of the following in the last 14 days?

- |                               |                                    |
|-------------------------------|------------------------------------|
| _____ Facial Cosmetic Surgery | _____ Chemical Exfoliation (peels) |
| _____ Botox Injections        | _____ Extractions                  |
| _____ Collagen Injections     | _____ Permanent Cosmetics          |
| _____ Skin Cancer             | _____ Waxing                       |
| _____ Dermatitis              | _____ Laser Hair Removal           |
| _____ Keloid Scarring         | _____ Microdermabrasion            |
| _____ Laser resurfacing       |                                    |

**Home Care**

What skincare products are you currently using at home?

- |                   |                  |
|-------------------|------------------|
| Cleanser _____    | Vitamin C _____  |
| Toner _____       | Exfoliants _____ |
| Moisturizer _____ | SPF _____        |

Please check if you are currently using or have used in the past any of the following:

- |                             |  |
|-----------------------------|--|
| _____ Benzoyl Peroxide (BP) | _____ Tretinoin (Retin A, Retin -A Micro®, Renova) |
| _____ Glycolic Acid (AHA)   | _____ Adapalene (Differin®)                        |
| _____ Lactic Acid (AHA)     | _____ Azelaic Acid ( Azelex®, Finacea™)            |
| _____ Resorcinol            | _____ Tazarotene (Tazorac®)                        |
| _____ Salicylic Acid        | _____ Isotretinoin (Acutane)                       |
| _____ Sulfur                | _____ Vitamin A                                    |

