



Acne Skin Treatment CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

MEDICATIONS

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		

MEDICAL HISTORY – please check all that apply ✓

Herpes Simplex	HIV/AIDS	Hemophilia	
Eczema	Thyroid Problems	Lupus	
Psoriasis	Hormone Problems	Anemia	
Hepatitis	Hysterectomy	High Blood Pressure	
Cancer	Ovary(ies) Removed	Diabetes	
Staph Infection/MRSA	Pacemaker	Metal Pins in Body	

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care? Yes No

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

- Have you ever had any reaction to any products or anything you have put on your face? Yes No
If yes, what products? _____
- Please check any of these you are allergic to: Sulfur Aspirin Latex
List any other allergies you know of: _____
- Do you smoke? Yes No
- Do you use fabric softener or fabric softener sheets in the dryer? Yes No
- Do you swim in a chlorinated pool? Yes No
- Do you work around chemicals, tars, oils, grease or inks? Yes No
- Occupation: _____ Do you work nights? Yes No
- Are you currently under a lot of stress? Yes No (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
- Women:** Do you use birth control pills, shots or use an IUD? Yes No
If so, which do you use? _____ What brand of pill? _____
Are you pregnant or nursing? Yes No
- Men:** Do you have shaving irritation? Yes No
What do you use for shaving? _____
- Diet – do you consume the following?

Foods	✓	How often per week	Foods	✓	How often per week
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins		
Peanut Butter			Seafood		

PRODUCTS CURRENTLY USING – Provide product names.

Cleanser	
Toner	
Serums	
Moisturizers	
Sun Screen	
Mask	
Foundation	
Blush	
Exfoliant (acids or scrubs)	
Acne Medications	

Anything Else?	
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OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

Glycolic/Lactic/Mandelic Peels	When?	Where?
Other Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us? _____