



## CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

### PATIENT/CLIENT INFORMATION

DATE \_\_\_\_\_  
 NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_  
 CELL \_\_\_\_\_  
 EMAIL \_\_\_\_\_

### MEDICAL INFORMATION

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_  
 DO YOU SMOKE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_ LIVING WITH A SMOKER? \_\_\_\_\_  
 HAVE YOU BEEN TREATED FOR: (PLEASE CIRCLE)  
 ACNE DEPRESSION SKIN DISEASE HIGH BLOOD PRESSURE COLD SORES DIABETES CANCER  
 LIST OF ALL ALLERGIES/ALLERGIC \_\_\_\_\_  
 LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING \_\_\_\_\_  
 ARE YOU PREGNANT? \_\_\_\_\_ TRYING TO GET PREGNANT? \_\_\_\_\_ HORMONE THERAPY? \_\_\_\_\_ ARE YOU PRONE TO COLD SORES? \_\_\_\_\_

### PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? \_\_\_\_\_ DO YOU TAKE SUPPLEMENTS/VITAMINS? \_\_\_\_\_

DO YOU EXERCISE? \_\_\_\_\_ IF SO, HOW OFTEN: \_\_\_\_\_ YOUR LAST SUNBURN? \_\_\_\_\_ DO YOU USE TANNING BEDS? \_\_\_\_\_

WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE ONE):

ALWAYS BURN (I) USUALLY BURN (II) SOMETIMES BURN (III) RARELY BURN (IV) VERY RARELY BURN (V) NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A:

DERMATOLOGIST \_\_\_\_\_ PLASTIC SURGEON \_\_\_\_\_ ESTHETICIAN \_\_\_\_\_ WOULD YOU BE INTERESTED IN COSMETIC SURGERY? \_\_\_\_\_

IF YES, WHAT PROCEDURE? \_\_\_\_\_

WHAT SKIN LINE ARE YOU CURRENTLY USING? \_\_\_\_\_

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)? \_\_\_\_\_ IF NOT, WHY? \_\_\_\_\_

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN:

(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS? (PLEASE CIRCLE ONLY ONE):

NORMAL DRY/DEHYDRATED OILY ACNE/ACNE PRONE ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

\_\_\_\_ REDUCTION OF FINE LINES

\_\_\_\_ REDUCTION OF BROWN SPOTS/SUN DAMAGE

\_\_\_\_ REDUCTION OF OIL/ACNE

\_\_\_\_ ACNE SCARS DIMINISHED

\_\_\_\_ REDUCTION OF REDNESS

### TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

1. CLEANSE \_\_\_\_\_ 1. CLEANSE \_\_\_\_\_  MASQUE \_\_\_\_\_

2. ANTI-AGE \_\_\_\_\_ 2. ANTI-AGE \_\_\_\_\_  EYE TREATMENT \_\_\_\_\_

3. PROTECT \_\_\_\_\_ 3. REPAIR \_\_\_\_\_  BLEACHING \_\_\_\_\_

PROFESSIONAL TREATMENT RECOMMENDATION

CHEMICAL PEEL MICRODERMABRASION DUAL PEEL

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.  
 THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_