**250 Fountain Court**
**Lexington, KY 40509**
**(859)977-2312**

# Skincare History Questionnaire

Date: _____________ Chart #: ______________ Name: _________________________________
Referring Doctor: __________________________ Date of Birth: _____________ Age: ________
Sex: ______ Home Phone #: _____________________ Cell #: ___________________________
Business Phone #: ___________________ E-mail address: ________________________________

## Health History

What type of work do you do? ____________________________________________________
Have you seen a Dermatologist in the past year? Yes _____ No _____
Are you presently under a Physician's care? Yes _____ No _____
Are you currently taking any medications? Yes _____ No _____ If yes, please list: _________
________________________________________________________________________________
What is your genetic background? _________________________________________________
How is your health? Excellent _____ Good _____ Fair _____ Poor _____
Please circle the following conditions you have or you have experienced:

hypertension cold sores anemia cancer seizures headaches
metal plate hernia lupus thyroid disorders eating disorder asthma
diabetes stroke irregular pulse high cholesterol heart attack hepatitis
fainting contact lenses claustrophobia varicose veins epilepsy tooth fillings
high/low blood pressure

Do you take nutritional supplements? Yes _____ No _____
Do you exercise? Yes _____ No _____
Do you have a tendency to scar? Yes _____ No _____
Do you smoke? Yes _____ No _____

**Allergies:**
Have you ever had an allergic reaction to any of the following:
Aspirin or Salicylates Yes _____ No _____
Milk Yes _____ No ______
Apples Yes _____ No _____
Citrus Yes _____ No _____
Grapes Yes _____ No _____
Ingredients in skincare products Yes _____ No _____
Fish, marine or iodine allergies Yes _____ No _____
Latex Yes _____ No _____
Sulfur Yes _____ No _____
If checked yes to any of the above, please explain ___________________________________
Please list any other known allergies: ______________________________________________
Have you ever had Herpes Simplex? Yes _____ No _____

Female patients only:
Are you on hormone replacement therapy? Yes _____ No _____
Are you presently taking birth control pills? Yes _____ No _____
Are you pregnant, nursing, or planning to become pregnant? Yes_____ No _____
Are you prone to having seizures? Yes _____ No _____
Are you claustrophobic? Yes ____ No _____

**Skincare History:**
Are you currently having skin treatments? Yes _____ No _____
If yes, what type of treatment(s)______________________________________________
________________________________________________________________________

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

_____ Benzoyl Peroxide (BP)
_____ Glycolic Acid (AHA)
_____ Lactic Acid (AHA)
_____ Resorcinol
_____ Salicylic Acid (BHA)
_____ Sulfur
_____ Vitamin A
_____ Vitamin C
_____ Hydrocortisone (HC)
_____ Hydroquinone (HQ)

Do you have or have you had any of the following treatments previously?

_____ Facial Cosmetic Surgery
_____ Botox injections
_____ Collagen injections
_____ Fillers
_____ Light Treatments
_____ Laser Resurfacing
_____ Chemical Exfoliation (Peels)
_____ Extractions
_____ Permanent Cosmetics
_____ Waxing
_____ Laser Hair Removal
_____ Hair Treatments (perms, color, etc.)

If so, have you had any of the treatments in the last 14 days? Yes ____ No _____
Which one(s)? ____________________________________________________________

**Home Care:**
What skincare products are you currently using at home?
Cleanser _________________________
Toner ___________________________
Moisturizer _______________________
SPF _____________________________
Vitamin C ____________________________
Exfoliants/Scrubs _____________________
Specialty Products _____________________
Mask _______________________________

Please check if you are presently or have experienced any of the following:

_____ Skin Cancer
_____ Dermatitis
_____ Keloid Scarring
_____ Acne
_____ Rosacea
_____ Broken Capillaries
_____ Treatment Reactions
_____ Hypopigmentation
_____ Hyperpigmentation

Please check if you taking or have taken any of the following prescription products:

_____ Tretinoin (Retin-A, Renova, Avita)
_____ Adepalene (Differin®)
_____ Azelaic Acid (Azelex®, Finacea™)
_____ Tazarotene (Tazorac®)
_____ Isotretinoin (Accutane) Date of completion:
_____ Triluma™
_____ Metrogel

Any other topical antibiotics ______________________________________________________

Do you take any herbal supplements or Vitamins? Yes _____ No _____

If so, please list which ones? ______________________________________________________

Sun Protection:

Do you use a sunscreen? Yes _____ No _____

What level of protection? ________________

Do you sunbathe or participate in outdoor activities? Yes _____ No _____

Do you tan in a tanning booth? Yes _____ No _____

Have you tanned in a tanning booth in the last 14 days? Yes _____ No _____

Have you had any direct sun exposure in the last 10 days? Yes _____ No _____

When exposed to the sun do you:

_____ Always burn, never tan
_____ Always burn, sometimes tan
_____ Sometimes burn, sometimes tan
_____ Always tan

Do you feel your skin is sensitive? Yes _____ No _____

What skin condition do you want to improve?

_____ Acne and/or breakouts
_____ Facial Scarring
_____ Hyperpigmentation (freckles, age spots)
_____ Hypopigmentation
_____ Enlarged Pores
_____ Fine lines and Wrinkles
_____ Unwanted hair
_____ Rosacea
_____ Uneven Tone
_____ Uneven Texture
_____ Dehydration
_____ Oily
_____ Sun Damage

Other: ________________________________________________________________________

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

Patient Signature: ________________________________________ Date: ___________________

Skincare Specialists Signature: _____________________________ Date: ___________________