

# Medical Health History & Skin Questionnaire

Name: \_\_\_\_\_ Gender: M F Birth date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Zip: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Have you been or are you currently under the care of a physician within the past year? Yes No  
 2. Have you seen a dermatologist in the past year? Yes No  
 3. Are you currently taking any medications, antibiotics or topical medications? Yes No  
 If yes, please list: \_\_\_\_\_  
 5. Are you currently having skin treatments? Yes No If yes, what? \_\_\_\_\_  
 6. Have you ever had Cold sores/Herpes Simplex Virus? Yes No  
 If yes, are you using Denavir (Penciclovir), Zovirax (Acyclovir) or Abreva? Yes No  
 7. Do you use a sunscreen? Yes No If yes, what level of protection? \_\_\_\_\_

**8. Please circle if you are presently experiencing or have any of the following:**  
 Skin Cancer                      Dermatitis                      Keloid Scarring                      Rosacea                      Acne  
 Broken Capillaries                      Treatment Reactions                      Hypopigmentation                      Hyperpigmentation

**9. Do you have any allergies?** Yes No If yes, what? \_\_\_\_\_  
**Have you ever had an anaphylactic reaction?** Yes No  
**Have you ever had an allergic reaction to any of the following?**

AHA's	Yes	No	Aspirin or Salicylates	Yes	No
Alcohol based products	Yes	No	Aloe Vera	Yes	No
Animals	Yes	No	Apples	Yes	No
Benzoyl Peroxide	Yes	No	Blood Transfusions	Yes	No
Citrus	Yes	No	Cosmetics	Yes	No
Drugs	Yes	No	Eggs	Yes	No
Fish, Marine or Iodine	Yes	No	Food	Yes	No
Grapes	Yes	No	Human Albumin	Yes	No
Hydroquinone	Yes	No	Ingredients in Skincare Products	Yes	No
Latex	Yes	No	Milk	Yes	No
Perfumes/Fragrances	Yes	No	Pollen	Yes	No

**10. Please circle if you have had any of the following in the last 14 days:**  
 Botox    Fillers    Laser Treatments    Microdermabrasion    Other \_\_\_\_\_

**11. Please circle any of the following prescription products that you have used or are currently using:**  
 Tretinoin (Retin A, Retin-A Micro, Renova, Avita)                      Adepalene (Differin)                      Triluma  
 Azelaic Acid (Azelex, Finacea)                      Tazarotene (Tazorac)                      Metrogel

If any, what strength? \_\_\_\_\_ How long? \_\_\_\_\_ How frequently? \_\_\_\_\_  
 Have you ever taken Accutane? Yes No If yes, when did you stop? \_\_\_\_\_

**12. What skincare products are you currently using at home?**  
 Cleanser \_\_\_\_\_ Vitamin C \_\_\_\_\_  
 Toner \_\_\_\_\_ Exfoliant/Scrub \_\_\_\_\_  
 Moisturizer \_\_\_\_\_ Serums \_\_\_\_\_

**13. What areas of concern do you have regarding your: (Please circle any that apply)**

Acne and/or breakouts	Blackheads/whiteheads	Broken capillaries/redness
Dehydrated	Dull/dry skin	Enlarged pores
Excessive Oil/Shine	Facial scarring	Fine lines and wrinkles
Flaky skin	Hyper pigmentation (freckles/spots)	Hypo pigmentation
Rosacea	Sun spot/liver spot/brown spot	Sun damage
Uneven skin tone	Other: _____	

**14. Do you have any of the following medical conditions:**

ALS	Lupus	Seizures
Asthma	Anemia	Artificial Implants/Metal Plate
Autoimmune	HIV	Skin Disorders
Blood disorder or clotting	Heart Condition/ Pacemaker	Thyroid Disorders
Cancer	Hypertension/high/low blood pressure	Hepatitis
Diabetes	Hormone imbalance	Parkinson's Disease
Eye Disease	PCOS / ovarian cysts	Hidradenitis Suppurativa
Neurological Disorder	Kidney Disease	Numbness
Phlebitis	Psoriasis	Spinal/Muscle Conditions

Any other medical conditions or anything else we should know about before/while treating you?

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***I acknowledged that all the information provided by me in this questionnaire is true and correct to the best of my knowledge. I understand that 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 types and conditions.***

X \_\_\_\_\_ Date: \_\_\_\_\_  
Client Signature

X \_\_\_\_\_  
Printed Name

