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PROFESSIONAL ACNE CARE

Client Questionnaire

Your Information

Name _____ Age _____DOB _____ Ethnicity_____

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		

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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 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 □

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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 type of razor 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- Please Provide Product Names

Cleanser	
Toner	
Serums	
Moisturizers	
Sunscreen	
Mask	
Foundation	
Blush	
Exfoliant (acids, serums, scrubs)	
Acne Medications	
Anything Else?	

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Other Treatments: What else have you done for your skin in the last 90 days?

Treatment	When?	Where?
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? _____