

## Skin Care Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Email: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Are you pregnant? \_\_\_\_\_ Do you wear contacts? \_\_\_\_\_  
Do you currently have a sunburn//windburn/red face? \_\_\_\_\_  
Do you use tannin beds? \_\_\_\_\_ Last time? \_\_\_\_\_  
Do you currently get facial waxing/electrolysis or use depilatories? \_\_\_\_\_ Last time? \_\_\_\_\_  
Do you use Biore/snore strips? \_\_\_\_\_ Last time? \_\_\_\_\_  
Are you currently using Retin-A/Renova/Differin? \_\_\_\_\_ What strength? \_\_\_\_\_  
How long? \_\_\_\_\_ How frequently? \_\_\_\_\_ Where applied? \_\_\_\_\_  
Are you currently using tazorac? \_\_\_\_\_ Are you currently using Accutane? \_\_\_\_\_  
Are you currently having microdermasion? \_\_\_\_\_ Last time? \_\_\_\_\_  
Do you have regular collagen injections? \_\_\_\_\_ Last time? \_\_\_\_\_  
Do you have botox injections? \_\_\_\_\_ Last time? \_\_\_\_\_  
What type of work do you do? \_\_\_\_\_  
Do you participate in vigorous aerobic activity or sports? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had a peel? \_\_\_\_\_ In the last 14 days? \_\_\_\_\_  
What kind? \_\_\_\_\_  
Have you recently had facial surgery? \_\_\_\_\_ Area: \_\_\_\_\_ When? \_\_\_\_\_  
Have you recently had laser resurfacing? \_\_\_\_\_ Area: \_\_\_\_\_ When? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_  
Ever develop cold sores/fever blisters? \_\_\_\_\_ Last time? \_\_\_\_\_  
Are you allergic or sensitive to: grapes aspirin mushrooms apples citrus  
perfumes latex hydroquinone aloe vera milk  
Any other allergies? If so, what? \_\_\_\_\_  
Are you sensitive to alcohol-based products? List: \_\_\_\_\_  
Are you on any medications? If so, please list all: \_\_\_\_\_  
Do you consider your skin: Sensitive Resilient Not sure  
Hair color: Blonde Red Lt. Brown Med. Brown Dk. Brown Black Gray Silver  
Eye color: Blue Hazel Green Lt. Brown Med. Brown Dk. Brown  
Skin tone: Pale/White Light Medium Reddish Freckled Lt. Olive Med. Olive  
Dk. Olive Lt. Brown Med. Brown Dk. Brown Soft Black Black Sallow  
What is your hereditary makeup? \_\_\_\_\_  
Have you ever used products that caused a bad reaction? \_\_\_\_\_ Please list: \_\_\_\_\_  
What is your daily home care regimen? \_\_\_\_\_

What cosmetic improvements would you like to see in your skin? \_\_\_\_\_

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

### **Aesthetician Notes:**

Treatment recommendation:

Patch Test: Date: \_\_\_\_\_ Solution: \_\_\_\_\_ Result: \_\_\_\_\_