

 **CLIENT** **QUESTIONNAIRE**

**YOUR** **INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_

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 |  |  |

**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** **skin** **physician’s** **care?** Yes □ No □

If yes, doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIFESTYLE** **CONSIDERATIONS**

1. Have you ever had any reaction to any products or anything you have put on your face? Yes □ No □

If yes, what products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Please check any of these you are allergic to: Sulfur □ Aspirin □ Latex □

List any other allergies you know of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Do you smoke? Yes □ No □

4. Do you use fabric softener or fabric softener sheets in the dryer? Yes □ No □ 5. Do you swim in a chlorinated pool? Yes □ No □

6. Do you work around chemicals, tars, oils, grease or inks? Yes □ No □

7. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you work nights? Yes □ No □

8. 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)

9. **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 □

10. **Men:** Do you have shaving irritation? Yes □ No □

What do you use for shaving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. 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 |  | i | Vitamins |  |  |
| Peanut Butter |  |  | Seafood |  |  |

**PRODUCTS** **CURRENTLY** **USING** **–** **Provide** **product** **names.**

|  |  |
| --- | --- |
| Cleanser |  |
| Toner |  |
| Serums |  |
| Moisturizers |  |
| Sun Screen |  |
| Mask |  |
| Foundation |  |
| Blush |  |
| Exfoliant (acids or scrubs) |  |
| Acne Medications |  |
| Anything Else? |  |

**OTHER** **TREATMENTS:** **What** **else** **have** **you** **done** **for** **your** **skin** **in** **the** **last** **90** **days?**

|  |  |  |
| --- | --- | --- |
| Glycolic/Lactic/Mandelic Peels | When? | Where? |
| Other 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** **me?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_