Cosmetic Client Questionnaire

Client Name_____Today's Date_____
Date of Birth_____Age_____Occupation_____
Address_____City_____State___Zip Code_____
Cell phone_____Home Phone_____Work Phone_____
Emergency Contact name, relationship, and Phone_____
How were you referred to us?_____

Skin Type:

I	Creamy complexion Always burns easily, never tans
II	Light Complexion Always burns, tans slightly
III	Light/Matte Complexion Burns moderately, tans gradually
IV	Tan/Light Brown Complexion Seldom burns, always tans well
V	Brown Complexion Rarely burns, deep tan
VI	Dark brown/Black Complexion Never burns, deeply pigmented

For Fitpatrick skin classification:
Ethnicity?_____
Do you have any Asian, Native American, Middle Eastern, or Latin American ancestry?_____

Medical

Are you currently under the care of a physician? __Yes__No
If yes, for what:_____
Are you currently under the care of a dermatologist? __Yes__No
If yes, for what:_____
What oral medications are you currently taking? __ Birth control __ Hormones__Antibiotics
Others (please list):_____
Are you on any mood altering or antidepressant medications?_____
Have you ever used Accutane? __ Yes __ No If yes, when did you last use it?_____
What topical medications or creams are you currently using? __ Retin A __ Others (please list)
_____
What herbal supplements do you use regularly_____
For women: Are you pregnant or trying to become pregnant __ Yes __ No
Are you breastfeeding? ___ Yes __No

YES	NO	
___	___	Allergies – history of severe allergy or anaphylaxis or hives
___	___	Allergic reaction to __Food __Latex __Aspirin __Lidocaine __Hydrocortisone ___Hydroquinone__Numbing medication
___	___	Taking aspirin or ibuprofen? If yes, when was last dose? _____
___	___	Autoimmune disease, Rheumatoid arthritis, HIV, Lupus, Hepatitis
___	___	Diabetes
___	___	Bruise easily/excessive bleeding/bleeding disorder?
___	___	Currently breastfeeding or pregnant?
___	___	History of keloid or thick or raised scar formation after a cut or burn?
___	___	Cancer or currently on immunosuppressive therapy
___	___	Currently tanning or tanning booth
___	___	Recent self-tanning lotions or treatments
___	___	Any hyperpigmentation (darkening of skin) or hypopigmentation (lightening of skin)
___	___	History of oral herpes (cold sores)
___	___	History of erythema abigne, persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation

YES NO

___ ___ Amyotropic lateral sclerosis, Eaton-lambert syndrome, facial bleeding
___ ___ Facial paralysis
___ ___ Any rash or infection on face or active infection?
___ ___ Currently taking any antibiotics? _____
___ ___ Any condition not listed or under provider's care for any condition.
List: _____
___ ___ Do you participate in vigorous aerobic activity or sports? Times per week: _____
___ ___ History of nasal or facial or plastic surgery?

Lifestyle

YES NO

___ ___ Do you consume alcohol?
___ ___ Do you smoke?
___ ___ Do you exercise regularly?
___ ___ Do you tan?
___ ___ Do you wear sunscreen daily that is SPF 30 or greater?

Describe your history of sun exposure:_____

Cosmetic History

YES NO

___ ___ Dermal fillers (Juvederm, Restylane, Perlane, Radiesse, Sculptura) When last? _____
___ ___ Botox/Dysport/Xeomin When was it last done? _____
___ ___ Chemical peels
___ ___ Laser treatment What kind(s) have you used in the past and when last used?_____

Please indicate, by brand name, products you use for daily skin care:

What conditions currently apply to your skin:

__ Uneven skin tone __ Facial hair __Lip lines __ Fine lines/wrinkles
__ Hyperpigmentation __ Facial capillaries __ Age spots __ Loss of volume
__ Acne/acne scars __ Enlarged pores __ Sagging skin__Recent weight loss

Please indicate any treatments you may have an interest in:

__Botox (for frown lines, crow's feet, forehead lines, nose lines)
__Microneedling (for improving acne scars, fine lines and wrinkles, including around the eyes, smaller pores, smoother skin, decreased pigmentation)
__Eyelash extensions
__IPL (for improving brown spots such as age spots, sun spots, liver spots or facial redness such as rosacea, spider veins, etc)
__Hair removal (any part of body)
__Nonsurgical skin tightening (below the chin, lower face, neck, abdomen, thighs, upper arms)

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the staff of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____