

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT / CLIENT INFORMATION

Date _____ Name _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

MEDICAL INFORMATION

Date of Birth _____ Age _____ Family Physician _____
Do you smoke? _____ How often? _____ Do you live with a smoker? _____
Have you been treated for: (circle all that apply)
Acne Depression Skin Disease High Blood Pressure Cold Sores Diabetes Cancer
List all allergies/allergic reactions to any product: _____
List all medications that you are currently taking: _____
Are you pregnant? _____ Trying to get pregnant? _____ Are you on hormone therapy? _____ Do you get cold sores? _____

PERSONAL INFORMATION

Circle your current level of stress: 1 2 3 4 5 6 7 8 9 10
Circle your normal level of stress: 1 2 3 4 5 6 7 8 9 10
Do you exercise? _____ If so, how often: _____ When was your last sunburn? _____
Do you use tanning beds? _____ If yes, please explain why _____ Have you used Retin A? _____
When you go out into the sun, do you: (circle one)
Always Burn(I) Usually Burn(II) Sometimes Burn(III) Rarely Burn(IV) Very Rarely Burn(V) Never Burn(VI)
Have you ever been under the treatment of a: Dermatologist _____ Plastic Surgeon _____ Esthetician _____
What skin line are you currently using: _____ Makeup brand: _____
Do you wear an environmental protection cream daily? _____ If not, why _____
Circle how you feel about the overall quality of your skin: 1 (bad) 2 3 4 5 6 7 8 9 10 (Fantastic)
Your skin type is (circle ONLY one): Normal Dry/Dehydrated Oily Acne/Acne Prone Rosacea
In order of importance, make a wish list of what you would like to see improved in your skin in the next 30 days
____ Reduction of fine lines _____ Reduction of brown spots/Sun Damage
____ Reduction of oil/acne _____ Acne scars diminish
____ Reduction of Redness _____ Reduce Pore Size
____ Hair Removal IPL _____ Hair Removal Waxing

Signature: _____ Date: _____
Physician: _____ Date: _____

SKIN TYPING WORKSHEET

Client Name:		Date:				
Score:		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy Red	Blonde	Dark blonde, chestnut, Brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or none at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always
Add above column for Total Score:		Match your total score with the corresponding skin type.		Fitzpatrick Skin Type		
	0-7 8-16 17-25 26-30 Over 30	I II III IV V-VI				