



## Regional Skin and Laser Patient Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are your short-term and long-term goals? \_\_\_\_\_

Are you planning to attend a special event (wedding, reunion, other)? If so when? \_\_\_\_\_

### Skin Care Regimen

#### Skin Type:

\_\_\_\_ Caucasian \_\_\_\_ African-American \_\_\_\_ Hispanic \_\_\_\_ Asian \_\_\_\_ Indian \_\_\_\_ Other: \_\_\_\_\_

Would you say your skin is: \_\_\_\_ Dry \_\_\_\_ Oily \_\_\_\_ Combo \_\_\_\_ Normal \_\_\_\_ Sensitive

#### Products You Currently Use:

Cleanser \_\_\_\_\_

Eye Cream \_\_\_\_\_ Exfoliant \_\_\_\_\_

Moisturizer (day) \_\_\_\_\_ (night) \_\_\_\_\_

Retinol/AHA/Glycolic \_\_\_\_\_

Serum \_\_\_\_\_ Toner \_\_\_\_\_

Other \_\_\_\_\_

What do you like about your current products? \_\_\_\_\_

What do you dislike about your products? \_\_\_\_\_

How much UV exposure do you get? (sun, tanning beds, driving, etc) \_\_\_\_\_

Have you recently used any self-tanning lotions, creams, or tanning sprays? \_\_\_\_ Yes \_\_\_\_ No

Are you planning a holiday in the sun? \_\_\_\_ No \_\_\_\_ Yes, if so when? \_\_\_\_\_

Do you have any metal devices or a pacemaker? \_\_\_\_\_

### Medical History

\_\_\_\_ Cold Sores \_\_\_\_ Heart Disease \_\_\_\_ Depression \_\_\_\_ Hypertension \_\_\_\_ Easily Bruise

\_\_\_\_ Fever Blisters \_\_\_\_ Stroke \_\_\_\_ Anemia \_\_\_\_ Sleep Apnea \_\_\_\_ Kidney Problems

\_\_\_\_ Bleeding Tendency \_\_\_\_ Heart Murmur \_\_\_\_ Hepatitis \_\_\_\_ Arthritis \_\_\_\_ Glaucoma

\_\_\_\_ High Cholesterol \_\_\_\_ Anorexia \_\_\_\_ HIV/AIDS \_\_\_\_ Seizures \_\_\_\_ Liver Disease

\_\_\_\_ Heart Attack \_\_\_\_ Anxiety \_\_\_\_ Diabetes \_\_\_\_ Cancer \_\_\_\_ Thyroid

Height \_\_\_\_\_ Weight \_\_\_\_\_

What medications/vitamins/hormones are you on? \_\_\_\_\_

Are you allergic to any of the following? \_\_\_\_ Latex \_\_\_\_ Asprin \_\_\_\_ Lidocaine \_\_\_\_ Hydrocortisone \_\_\_\_ Hydroquinone

Other Allergies: \_\_\_\_\_

Are you taking any antibiotics? \_\_\_\_\_ Are you taking any blood thinners? \_\_\_\_\_

Have you ever used Accutane? \_\_\_\_ No \_\_\_\_ Yes, if so for how long? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Are you breastfeeding? \_\_\_\_\_

Have you ever had plastic or cosmetic surgery? \_\_\_\_ No \_\_\_\_ Yes, if so when? \_\_\_\_\_

Have you ever had a laser treatment? \_\_\_\_ No \_\_\_\_ Yes, if so what kind? \_\_\_\_\_ and when? \_\_\_\_\_

Have you used the following in the last 6 weeks? \_\_\_\_ Shaving \_\_\_\_ Waxing \_\_\_\_ Electrolysis

\_\_\_\_ Tweezing \_\_\_\_ Threading \_\_\_\_ Depilatories

Do you have any hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma or scars? \_\_\_\_\_

Do you have acne? \_\_\_\_\_ Have you been diagnosed or treated for skin cancer? \_\_\_\_\_