Medical Aesthetics Questionnaire

Name:_____Name you prefer we use: _____
Date:_____Age: _____Who may we thank for your referral?_____

Have you ever had the following procedures: (peel, laser, IPL, surgery or microderm)? No/Yes, circle which one/s. When was your last treatment? _____

Which concerns apply to your skin? Please circle all that apply:

Acne	Scarring	Clogged Pores
White Spots (Hypopigmentation)	Fine Lines / Wrinkles Skin	Volume Loss in Lips
	Laxity	Bumps Under Skin
Uneven Skin Tone	Sensitivity / Redness	Bags under eyes
Blackheads / Whiteheads / Milia	Brown Spots (Hyperpigmentation)	Dryness
		Hair Loss
Excessive Oiliness	Tired Looking Eyes	Hair Removal

Other Concerns Please List:
_____

Please check the skincare products you currently use & their brand names:

Cleanse_____
SPE_____
Exfoliant_____
Moisturizer/Day_____
Serum_____
Moisturizer/Night_____
___
Retinol/AHA/Glycolic_____
Other Please List_____

Please check any that pertain to your health:

Skin Cancer (history of, or currently) - Where/When: _____
Contagious Conditions - Which one?_____
Immune Disorders? (ie Rheumatoid arthritis, sclerodermis, lupus?)

Epilepsy or Seizures	High Level of Stress	Blood Pressure-High/Low
Hepatitis C	Cold Sores	History of Anesthetic Reaction
Headaches / Migraines	Diabetes	
Circulation Problems	OHIV	

Is there anything else you would like the doctor to know? Or any other questions or concerns that have not been expressed?_____