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Acne Client Questionnaire

YOUR INFORMATION

NAME:	AGE:	DOB:	ETHNICITY:
ADDRESS:		CITY / STATE:	
ZIP:	CELL PHONE:		OTHER PHONE:
EMAIL:			

MEDICATIONS & DRUG HISTORY

Please indicate if you have used any of the following in the last 2 years, when, and for how long.

Antibiotics (oral) — When / How long:	**Retin-A, Tazorac, Differin** — When / How long:
Antibiotics (topical) — When / How long:	**Thyroid medication** — When / How long:
Accutane — When / How long:	**Blood Thinning Meds** — When / How long:
Benzoyl Peroxide — When / How long:	

Other medications or drugs used in the past 2 years, when, and for how long:

_____

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

PRIMARY CARE PHYSICIAN

NAME:	PHONE:

Are you under a dermatologist's or other physician's care? ☐ Yes ☐ No If yes, doctor's name: _____

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LIFESTYLE CONSIDERATIONS

Have you ever had any reaction to any products or anything you have put on your face? ☐ Yes ☐ No If yes, what products?

_____

Allergic to: ☐ Sulfur ☐ Aspirin ☐ Latex Other allergies: _____

Do you smoke/vape? ☐ Yes ☐ No If yes, what: _____

Do you use fabric softener or dryer sheets? ☐ Yes ☐ No

Do you swim in a chlorinated pool? ☐ Yes ☐ No

Do you work around chemicals, tars, oils, grease, or inks? ☐ Yes ☐ No

Occupation: _____ Do you work nights? ☐ Yes ☐ No

Are you currently under a lot of stress? ☐ Yes ☐ No (common triggers: job loss, new job, wedding, death in the family, graduation, long commute, heavily scheduled)

Do you use birth control pills, shots, or an IUD? ☐ Yes ☐ No If so, which / what brand? _____

Are you pregnant or nursing? ☐ Yes ☐ No

Do you have shaving irritation on your face? ☐ Yes ☐ No Type of razor used: _____

DIET — DO YOU CONSUME THE FOLLOWING?

Fast Food — how often/week:	Peanuts — how often/week:
Processed Food — how often/week:	Sushi — how often/week:
Salty Snacks — how often/week:	Kelp & Seaweed — how often/week:
Milk/Yogurt — how often/week:	Miso Soup — how often/week:
Cheese — how often/week:	Soy — how often/week:
Whey/Soy Protein — how often/week:	Vitamins/Supplements — how often/week:
Peanut Butter — how often/week:	Seafood — how often/week:

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SKINCARE PRODUCTS CURRENTLY USING

Cleanser	
Toner	
Serums	
Moisturizers	
Sunscreen	
Mask	
Foundation	
Blush	
Exfoliant (acids, serums, scrubs)	
Acne Medications	
Anything Else?	

OTHER TREATMENTS — LAST 90 DAYS

Treatment	**When?**	**Where?**
Chemical Peels (what kind?)		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other		

How did you hear about us? _____