Name____Age_____DOB____________________

Address__________________________________City_____________________State___Zip __________

Work Phone______________________________ Home Phone______________________________

Cell Phone_______________________________ Email address_________________________________

Ethnicity ____

Prescribed, Over the Counter and Recreational Drug/Medications (past and present use):

Medication	When	How Long	Medication	When	How Long
Antibiotics			Testosterone		
Accutane			Progesterone		
Benzoyl Peroxide			Disufuram		
Clindamycin Topical			Cyclosporin		
Adapalene			Dilantin		
Retin A Cream or Gel			Lithium		
Tazorac			Thyroid Medication		
Differin			Quinine		
Azelex			Isoniazid		
Sulfur			Immuran		
Clindamycin Oral			Danzol		
Androstendione			Gonadotrophin		
Cortisone			Steroids		
Minocycline			Recreational Drugs		
Copaxone			Antidepressants		

Products now using – please write product name

Cleanser________________________________

Toner_________________________________

Serums________________________________

Moisturizers_____________________________

SPF___________________________________

Mask__________________________________

Foundation______________________________

Blush__________________________________

Exfoliant (ex. Glycolic)_____________________

Acne Medications_________________________

Have you ever had <u>any</u> allergic reactions to any of the above products or anything you have ever put on your face?______

If yes, what product:_____________Describe:____

Check if you are allergic to: ____sulfur ____aspirin ____ latex Do you smoke?_____

Lifestyle Considerations

At what age did your acne start? _______

Do you use fabric softener or fabric softener sheets in the dryer? _____ Do you pick at your skin? ______

Do you work around chemicals, tars, oils or inks? ______ Are you currently under a lot of stress? ______

Do you regularly eat or ingest: ____kelp ____seaweed ____sushi ____ salt ____fast foods ____ milk/cheese

Women only: Are you on birth control pills? If yes, name of pill:_____________________________________

Are you taking Depo Provera shots?_________ Are you pregnant or nursing? ___________

What are your skin care concerns: **Describe your skin:**

____Blackheads	____Dehdyrated Skin	____Dry,Flaky Skin	____Oily
____Whiteheads	____Dark Spots	____Sensitive Skin	____Normal
____Pimples/Pustules	____Age Spots	____Razor Bumps	____Dry
____Cysts	____Broken Capillaries	____Shaving Irritation	____Oily/Dry
____Oily Skin	____Fine Lines/Wrinkles	____Acne Rosacea	____Sensitive

What else have you done for your skin:

Service	**When**	**Service**	**When**
____Glycolic Acid Peels		____Laser Hair Removal	
____Microdermabrasion		____Facial Waxing	
____Chemical Peels		____Electrolysis	
____Skin Cancer Removal		Anything else?	
____Plastic Surgery			

Medical History: check any condition you may have had in the past two years

____ Diabetes	____ Hepatitis	____ Hemophilia
____ Thyroid Problems	____ HIV + or AIDS	____ Thrombosis/Blood Clot/Stroke
____ Eczema	____ Staph Infection or MRSA	____ Metal pins or brackets in body
____ Psoriasis	____ Hormone Problems	____ Pacemaker
____ Pregnancy	____ Herpes Simplex/Cold Sores	____Hysterectomy/ovaries removed
____ Nursing	____ High Blood Pressure	____ PCOS
____ Cancer	____ Anemia	____ Lupus

Are you under a Dermatologist's Care? _____ If so, name of Dr. ___________________________________

What kind of work do you do?____

How did you hear about us?____

What results would you like to obtain with your skin? ____

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