SKINCYCLE

for all of your skin cycles

Client Questionnaire

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email address: _____

PART 1: Prescribed, over-the-counter and recreational drugs/medications (past & present)

Medication	When	How Long	Medication	When	How Long
Antibiotics			Testosterone		
Accutane			Progesterone		
Benzoyl Peroxide			Disulfiram		
Cleocin-T			Cyclosporin		
E-mycin-T			Dilantin		
Rein A Cream or Gel			Thyroid Medication		
Tazorac			Lithium		
Differin			Quinine		
Azelex			Isoniazid		
Sulphur			Imuran		
Avita			Danazol		
Androstenedione			Gonadotropin		
Cortisone			Steroids		
Minosine			Marijuana		
Copaxone			Cocaine/Speed		

PART 2: What else have you done for your skin?

Service	When	Service	When
Glycolic Acid Peels		Skin Care Removal	
Microdermabrasion		Facial Waxing	
Chemical Peels		Electrolysis	
Dermabrasion		Laser Hair Removal	
Plastic Surgery		Other:	

PART 3: Products you are currently using (please list product names)

Cleanser:
Toner:
Serums:
Moisturizers:
SPF:
Mask:
Foundation:
Blush
Exfoliation (ex: glycolic)
Acne Medications:

PART 4: Lifestyle considerations

1. Have you ever had any reactions to the above products or anything you have ever put on your face? ▢ Yes ▢ No

If yes, which product(s)? _____

Describe your reaction: _____

2. Please place a check if you are allergic to: ▢ Sulfur ▢ Aspirin ▢ Latex

3. Do you smoke? ▢ Yes ▢ No

4. Do you use fabric softener or fabric softener sheets in the dryer? ▢ Yes ▢ No

5. Do you pick at your skin? ▢ Yes ▢ No

6. Do you work around or with chemicals, tars, oils or inks? ▢ Yes ▢ No

7. Are you currently under a lot of stress? ▢ Yes ▢ No

8. Please place a check if you regularly eat or ingest:
▢ Kelp ▢ Seaweed ▢ Sushi ▢ Salt ▢ Fast Foods

9. WOMEN ONLY: Are you on birth control pills?
▢ Yes ▢ No If yes, which brand? _____
Are you taking Depo Provera shots? ▢ Yes ▢ No
Are you pregnant or nursing? ▢ Yes ▢ No

PART 5: Skincare Concerns (please check all that apply)

▢ Blackheads
▢ Dry, Flaky Skin
▢ Whiteheads
▢ Pimples/Pustule
▢ Cysts
▢ Oily Skin
▢ Acne Rosacea
▢ Shaving Irritation
▢ Dehydrated skin
▢ Sensitive Skin
▢ Dark Spots
▢ Age Spots
▢ Broken Capillaries
▢ Fine Lines/Wrinkles
▢ Razor Bumps

PART 6: Describe your skin type

▢ Oily
▢ Normal
▢ Dry
▢ Oily/Dry
▢ Sensitive

PART 7: Medical History (please check all that apply)

▢ Diabetes	▢ HIV Positive/AIDS	▢ Lupus
▢ Eczema	▢ Hormone Problems	▢ Thyroid Problems
▢ Psoriasis	▢ Hysterectomy	▢ Herpes Simplex
▢ Hepatitis	▢ Ovary(ies) Removed	▢ Anemia
▢ Cancer	▢ Hemophilia	▢ High Blood Pressure

Are you under a dermatologist's care? ▢ Yes ▢ No

If yes, what is your doctor's name? _____

PART 8: Miscellaneous

1. Occupation: _____
2. How did you hear about us? _____