Face It Beautiful
Acne Care & Skin Therapy

CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Cell Phone _____ Email _____

Permission to send monthly newsletter with skin care tips and program updates? Yes_____ No_____
(your email address will not be shared)

MEDICATIONS

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		

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	

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care? Yes □ No □

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

1. Have you ever had any reaction to any products or anything you have put on your face? Yes □ No □
   If yes, what products? _____
2. Please check any of these you are allergic to: Sulfur □ Aspirin □ Latex □
   List any other allergies you know of: _____
3. Do you smoke? Yes □ No □
4. Do you use fabric softener or fabric softener sheets in the dryer? Yes □ No □
5. Do you swim in a chlorinated pool? Yes □ No □
6. Do you work around chemicals, tars, oils, grease or inks? Yes □ No □
7. Occupation: _____ Do you work nights? Yes □ No □
8. Are you currently under a lot of stress? Yes □ No □ (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
9. **Women:** Do you use birth control pills, shots or use an IUD? Yes □ No □
   If so, which do you use? _____ What brand of pill? _____
   Are you pregnant or nursing? Yes □ No □
10. **Men:** Do you have shaving irritation? Yes □ No □
    What do you use for shaving? _____

11. Diet – do you consume the following?

Foods	✓	How often per week	Foods	✓	How often per week
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins		
Peanut Butter			Seafood		

PRODUCTS CURRENTLY USING – Provide product names.

Cleanser	
Toner	

Serums	
Moisturizers	
Sun Screen	
Mask	
Foundation	
Blush	
Exfoliant (acids or scrubs)	
Acne Medications	
Anything Else?	

OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

Glycolic/Lactic/Mandelic Peels	When?	Where?
Other Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us? _____