RHONDA | Ra | ALLISON®

# SKIN CARE HISTORY QUESTIONNAIRE

*Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.*

**Date** ____/____/____

| **Name** *(please print clearly)* First Last M.I. | | **Date of Birth** / / |
|---|---|---|
| **Street Address** | | |
| **City** | **State** | **Zip Code** |
| **Home Phone** ( ) | **Business Phone** ( ) | **Email** |

Please check if presently using any of the following? *(please ✓ all that apply)*

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C
❑ Hydroquinone ❑ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve *(please ✓ all that apply)*

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores
❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

**Female Clients**

Are you on hormone replacement therapy? ❑ Yes ❑ No
Are you presently taking birth control pills? ❑ Yes ❑ No
Are you pregnant or planning to be? ❑ Yes ❑ No

**All Clients**

Do you use a sunscreen/sun block? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you have or have ever had acne? ❑ Yes ❑ No
Are you using or have ever used any medications for acne? ❑ Yes ❑ No
Name of medication _____

Have you seen a Dermatologist in the past year? ❑ Yes ❑ No
If yes, list doctors name and reason for visit _____

Are you presently under a doctor's care? ❑ Yes ❑ No
What medications do you take on a regular basis?

Have you ever had Herpes (cold sores)? ❑ Yes ❑ No
Have you ever been treated with Zovirax or any medication for Herpes? ❑ Yes ❑ No

RHONDA | Ra | ALLISON®

# SKIN CARE HISTORY QUESTIONNAIRE

Do you have Epilepsy or Diabetes? ❑ Yes ❑ No
***If yes, you will be treated only with a doctors release!***

Are you presently under a physicians care for any reason? ❑ Yes ❑ No
***Explain*** _____

Do you use Biore or snore strips? ❑ Yes ❑ No

Have you had any of the following? ❑ Yes ❑ No *(please ✓ all that apply)*
❑ Cosmetic Surgery ❑ Botox Injections ❑ Skin Cancer ❑ Dermatitis ❑ Keloid Scarring
❑ Laser Resurfacing ❑ Chemical Peels ❑ Hepatitis ❑ Other (Specify) _____

Are you allergic to aspirin? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, list: _____

| | | |
|---|---|---|
| Do you smoke? | ❑ Yes | ❑ No |
| Do you take nutritional supplements? | ❑ Yes | ❑ No |
| Are you on a diet? | ❑ Yes | ❑ No |
| Do you exercise? | ❑ Yes | ❑ No |
| Do you wear contact lenses? | ❑ Yes | ❑ No |
| Have you had skin treatments (facials) before? | ❑ Yes | ❑ No |
| Are you currently having facials? | ❑ Yes | ❑ No |
| Have you had electrolysis or waxing in the past week? | ❑ Yes | ❑ No |
| Do you have those services done? | ❑ Yes | ❑ No |
| Have you had permanent cosmetics? | ❑ Yes | ❑ No |

If yes, where? _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What skin care products are you currently using? _____

_____

What is it about your skin you would like to change? _____

_____

Is there any other information I should know before beginning your treatment? _____

_____

**Client Signature** _____