

(continued on next page)

4) Do you have any special skin problems/concerns pertaining to your face or body? Yes No

Specify: _____

5) Have you ever had chemical peels, laser or microdermabrasion? No Yes

In the last month? No Yes

6) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? No Yes
Describe: _____

Have you used any of these products in the last 3 months No Yes

7) Have you used an acne medication? No Yes When? _____

Which drug? _____

8) What skin care products are you currently using? (List brand where known)

Soap _____

Toner _____

Mask _____

Eye Product _____

Cleanser _____

Day Moisturizer _____

Exfoliator _____

Scrubs _____

Shower Gels _____

Body Lotions _____

Sunscreen _____ SPF _____

Night Moisturizer/Cream _____

Other Makeup Products _____

9) Have you recently used any self-tanning lotions, creams or treatments? No Yes Specify:

10) Have you used any of the following hair removal methods in the past six weeks? No Yes Circle all that apply:

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

11) What areas of concern do you have regarding your skin (Please check any that apply and explain): Breakouts/acne
Broken capillaries Redness/ruddiness Flaky skin Sun spots/liverspots/brown spots Blackheads/whiteheads
Excessive oil/shine Uneven skin tone Rosacea Sun damage Wrinkles/fine lines Dull/dry skin Dehydrated skin
Other _____

Eyes: Dehydrated Wrinkles Puffiness Dark circles Other: _____

Lips: Dehydrated Cracked/chapped lips Other: _____

12) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain):

Cosmetics AHAs Medicine Fragrance Food Shellfish Animals Latex Sunscreens Drugs Iodine

Pollen Other _____ If other, please explain: _____

13) What SPF do you use on your face? _____ How often/when? _____

14) What SPF do you use on your body? _____ How often/when? _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes

Specify: _____

16) Have you experienced Botox, Restylane or Collagen injections? No Yes

Specify: _____

Female Clients Only:

17) Are you taking oral contraceptives? No Yes Specify: _____

18) Any recent changes to or from your contraceptive treatment? No Yes If yes, what and when:

19) Are you pregnant or trying to become pregnant? No Yes

20) Are you lactating? No Yes

21) Any menopause problems? No Yes

Specify: _____

22) Are you undergoing any hormone replacement therapy? No Yes

Specify: _____

Male Clients Only:

23) What is your current shaving system? Wet shave Electric

24) Do you experience irritation from shaving? No Yes Ingrown hairs? No Yes

Future Appointments/Contact:

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I ReGenesis Plastic Surgery & Skin Care Center from liability and assume full responsibility thereof.

Patient Signature: _____

Date: _____