COMPLEXIONS Rx
Beauty. Science. Progress.

SKIN CARE QUESTIONNAIRE

PERSONAL AND CONFIDENTIAL - PLEASE PRINT

NAME: ..... DATE: .....

ADDRESS: ..... PHONE DAY: .....

..... PHONE EVENING: .....

CITY: ..... E-MAIL ADDRESS: .....

STATE: ..... ZIP: ..... DATE OF BIRTH: .....

REFERRED BY ❍ FRIEND ❍ WALK-BY ❍ MAILING ❍ AD *(specify)* ..... ❍ OTHER *(specify)* .....

CONCERNS & INTERESTS

- What **skin problems or concerns** would you like to address? .....

.....

- What would you like to change about your skin? .....

.....

CURRENT HEALTH & LIFESTYLE

- Do you follow a **home skin care regimen**? ❍ No ❍ Yes If Yes, check the items and identify the name of the products you use regularly:

❍ eye makeup remover	❍ scrub/exfoliant	❍ retinol cream .....
❍ soap	❍ mask	❍ AHA product(s) .....
❍ cleanser	❍ eye cream	❍ benzoyl peroxide .....
❍ toner/astringent	❍ serum	❍ skin bleacher/lightener .....
❍ day cream	❍ sunscreen	❍ foundation .....
❍ night cream	❍ Retin-A®/Renova®	❍ other, list .....

- Have you had an **allergic or irritant reaction** to a **skin care product**(s)? ❍ No ❍ Yes Explain: .....

.....

- Do you **sunbathe**?
❍ No ❍ Yes How often: .....

- Do you use a **tanning booth**?
❍ No ❍ Yes How often: .....

- Do you use **sunscreen regularly**?
❍ No ❍ Yes SPF: .....

- Have you had **facial waxing** or used a **depilatory** in the past week? ❍ No ❍ Yes

- Have you ever had a **chemical peel**? ❍ No ❍ Yes If yes, which type: ..... , approximate date: ..... (mo./year)

- List all the **medications**, oral and topical, you are currently using or have used in the past six months

❍ Accutane®
❍ Steroids, topical or orally (ex: prednisone)
❍ Birth control pills
❍ Antibiotics, (please list) .....
❍ Other .....

- Please check if you have any of the following **health conditions**:

❍ Asthma/Hay Fever	❍ Cancer	❍ Hormonal conditions	❍ Cold sores/ fever blisters	❍ Hip or knee replacement
❍ Arthritis	❍ Heart disease			
❍ Diabetes	❍ Hepatitis	❍ Pregnancy	❍ Back injuries	

O-1: 10.12

Skin Care Questionnaire

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Dermatologic History

- When did you **last see a dermatologist**?

❍ Never
❍ 6 Months
❍ 1 Year
❍ 2 Year

- What types of **skin care treatments** have you had?

Treatment	*How long ago*

- Have you had any **cosmetic procedure** or **laser surgery** in the past six months? ❍ No ❍ Yes

If yes, please specify:.....

.....

- Do you take **aspirin** regularly? ❍ No ❍ Yes

- Please check if you have a **history** of the following **health conditions**:

❍ Bleeding Problems	❍ High Blood Pressure	❍ X-Ray Therapy	❍ Eczema
❍ Skin Cancer	❍ Hives	❍ Heart Murmur	❍ Fainting Spells
❍ Stomach Ulcers	❍ Tuberculosis	❍ Cardiac Pacemaker	❍ Other.....

- Any known **allergies to local anesthetics or medications**?

❍ No ❍ Yes If yes, please explain: .....

.....

- Are you **required to take antibiotics** prior to **surgical or dental procedures**?

❍ No ❍ Yes

Acknowledgement & Treatment Consent

I acknowledge that Complexions Rx scope of treatment is limited to minor skin concerns, cosmetics and esthetically oriented services. It is in no way a substitute or replacement for care by a dermatologist for healthcare concerns outside of the scope defined above. I remain responsible for my own dermatologic medical care including but not limited to conditions such as skin cancer, melanoma, psoriasis or eczema, among others. I therefore hereby release Complexions Rx and all of its employees or affiliates from all responsibility in connection with the diagnosis and treatment of such skin conditions.

I hereby authorize the Complexions Rx for treatment of cosmetic and minor skin care. I understand that I am financially responsible for services.

Client's signature:..... Date:.....

Please note: **It is extremely important to inform us during the course of your treatment of any changes in the usage of all medications including Accutane®, Retin-A® and other prescribed topical medications. It is for your protection and safety. Thank you for answering our questions. The information in this questionnaire is strictly confidential.**

O-1: 10.12