Skin Care Questionnaire

Name: ______________________ Chart #: ____________ Date: ____________

Please state your skin care goals: ______________________________

List all medications you are currently taking: ☐ None

1) ______________________
2) ______________________
3) ______________________
4) ______________________

Are you allergic/sensitive to: ☐ None

☐ milk ☐ aloe ☐ hydroquinone
☐ apples ☐ aspirin ☐ Others: (*list*)
☐ citrus ☐ latex ____________
☐ grapes ☐ perfumes ____________
☐ alcohol-based products ____________

Describe your skin (check those that apply)**:**

	Thick		Acne		Wrinkled		Sensitive
	Thin		Breakouts		Freckled		Resilient
	Saggy		Cysts		Hypo-pigmented		Not Sure
	Firm		Sun-damaged		Hyper-pigmented		
	Normal		Rosacea		Melasma		
	Dry		Acne Scarring		Milia		
	Oily		Uneven/blotchy		Dehydrated (*lacks moisture*)		
	Combination		Eczema		Asphyxiated (*smokers*)		
	Mature		Psoriasis		Telangiectasias (*broken capillaries*)		

Do any of the following items pertain to you? (currently)

☐ Herpes
☐ Pregnant
☐ Blood thinners
☐ St. Johns wart
☐ Menstrual dysfunction
☐ Smoker
☐ Sunbather/Tanning Beds
☐ Sunburn/Windburn

☐ Facial waxing
☐ Electrolysis
☐ Use depilatories
☐ Biore/snore strips
☐ Wear contact lenses
☐ Airline travel
☐ Regular collagen injections
☐ Regular Botox injections

☐ RetinA/Renova/Differin
Last dose: ________
☐ Tazorac
Last dose: ________
☐ Accutane
Last dose: ________
☐ Mircrodermabrasion
Last Tx: ________

Describe your:

Eyes:
☐ Blue
☐ Green
☐ Gray
☐ Brown

Hair:
☐ Blonde
☐ Red
☐ Brown
☐ Black
☐ Gray

Skin Tone:
☐ Light
☐ Medium
☐ Reddish
☐ Olive
☐ Lt. Brown
☐ Md. Brown
☐ Black

Have you recently had facial surgery? ☐ Yes When: ______________________ ☐ No

Describe: ______________________________

Have you ever had a peel? ☐ Yes What kind: ______________ When: ____________ ☐ No

Have you recently had laser resurfacing? ☐ Yes What kind: ______________________ ☐ No

When: ______________________

Have you ever used any products that caused a bad reaction: ☐ Yes ☐ No

Describe: ______________________________

What is your daily skin care regimen? ______________________________

____

Signed: ______________________ (patient) Reviewed: ______________________

Please complete both sides of this form

Medical Skin Solutions

Virginia Ear, Nose & Throat Associates

PATIENT DEMOGRAPHIC INFORMATION

CHART# ______________________

PATIENT NAME: ____
LAST FIRST MIDDLE

SEX: ☐ **F** ☐ **M** **AGE:** _______ **BIRTHDATE:** __________________________ **SS#:** _________________________

ADDRESS: ____
STREET CITY STATE ZIP

RESPONSIBLE PARTY: ____

ADDRESS: ____
STREET CITY STATE ZIP

HOME PHONE: ____________________ **WORK PHONE:** ____________________ **CELL PH:** __________________

OCCUPATION: ____

EMERGENCY CONTACT: ____ **PHONE:** _______________________

FINANCIAL POLICIES

- Our products and services are not covered by insurance and we require payments be made in full at the time of service.
- In the event that a check is returned for insufficient funds, we will call to notify you and give you 10 days to pay the amount of the check in full with cash. If we do not receive the cash payment in full within 10 days, a $25 returned check fee will be added to your account.
- In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

I have read the above Financial Policies and I understand and agree to them.

SIGNATURE: ____ **DATE:** _____________________________

Please complete both sides of this form