

## 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):

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

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

- Herpes
- Facial waxing
- RetinA/Renova/Differin
- Pregnant
- Electrolysis
- Last dose: \_\_\_\_\_
- Blood thinners
- Use depilatories
- Tazorac
- Last dose: \_\_\_\_\_
- St. Johns wart
- Biore/snore strips
- Accutane
- Last dose: \_\_\_\_\_
- Menstrual dysfunction
- Wear contact lenses
- Microdermabrasion
- Last Tx: \_\_\_\_\_
- Smoker
- Airline travel
- Sunbather/Tanning Beds
- Regular collagen injections
- Sunburn/Windburn
- Regular Botox injections

**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