

therapy at the CENTER FOR ADVANCED DERMATOLOGY

Aesthetic Questionnaire

The Following Questions Should be Answered If You Are Having an Aesthetic Consultation Today:

Please check all procedures, products, or issues that are of interest to you:

- | | |
|---|--|
| <input type="checkbox"/> Laser Hair Reduction | <input type="checkbox"/> Fine Lines/Wrinkles |
| <input type="checkbox"/> Intense Pulsed Light- IPL | <input type="checkbox"/> Stretch Marks |
| <input type="checkbox"/> Laser Skin Resurfacing | <input type="checkbox"/> Tretinoin - Date last used: _____ |
| <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Retin A or Renova - Date last used: _____ |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Accutane – Start & End Dates: : _____ |
| <input type="checkbox"/> Chemical Peels/Medical Facials | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Spider Vein Treatments (Legs) | <input type="checkbox"/> Skin Care Product Advice |
| <input type="checkbox"/> Reduction of Facial Vessels | <input type="checkbox"/> Facial Injectables |
| <input type="checkbox"/> Sun/Age Spot Treatments | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Melasma | |
| <input type="checkbox"/> Birthmark Reduction | |

Which skin conditions do you want to improve?

What skin care products do you currently use (i.e. cleanser, sunscreen, moisturizer, or makeup)?

- Have you ever had a reaction to any skin care products? Yes No
- Have you ever had herpes (cold sores)? Yes No
- Do you use sunscreen/sunblock on a daily basis? Yes No If yes, what type? _____
- Do you sunbathe, use tanning booths or participate in regular outdoor activities? Yes No
- Do you or have you ever had acne? Yes No
- Are you using any medications for acne? Yes No If yes, medication's name: _____
- Have you seen a Dermatologist in the past year? Yes No
- If yes, what is the doctor's name and purpose of the visit? _____

Please list any previous cosmetic procedures or treatments you have had including botox or fillers:

Women:

- | | |
|---|--|
| Are you on hormone replacement therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you presently taking birth control pills? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you planning to be or are you currently pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you nursing? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Name: _____

Date: _____