Client Questionnaire

YOUR INFORMATION

Name_____Age_____DOB_____Ethnicity_____

Address _____ City _____ State _____ Zip _____

Cell Phone _____Other Phone _____ Email _____

Please indicate if you have used any of the medications or drugs listed below in the last 2 years, when they were used, and for how long you used them.

MEDICATION	WHEN	HOW LONG	MEDICATION	WHEN	HOW LONG
Antibiotics (oral)					
Antibiotics (topical)					
Accutane					
Benzoyl Peroxide					
Retin-A, Tazorac, Differin					
Thyroid medication					
Blood Thinning Meds					

Please list any other medications or drugs listed that you have used in the past 2 years and include when they were used, and for how long you used them:_____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Herpes Simplex		HIV/AIDS		Hemophilia	
Eczema		Thyroid Problems		Lupus	
Psoriasis		Hormone Prolems		Anemia	
Hepatitis		Hysterectomy		High Blood Pressure	
Cancer		Ovary(ies) Removed		Diabetes	
Staph Infection/MRSA		Pacemaker		Metal Pins in Body	

YOUR PRIMARY CARE PHYSICIAN:

Name: _____ Phone: _____

Are you under a dermatologist's or other physician's care? Yes__ No__

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

Have you ever had any reaction to any products or anything you have put on your face? Yes___ No___

If yes, what products? _____

Please check any of these you are allergic to: Sulfur___ Aspirin___ Latex___

List any other allergies you know of: _____

Do you smoke/vape? Yes___ No___ If yes, what do you smoke _____

Do you use fabric softener or fabric softener sheets in the dryer? Yes___ No___

Do you swim in a chlorinated pool? Yes___ No___

Do you work around chemicals, tars, oils, grease or inks? Yes ___ No ___

Occupation: _____ Do you work nights? Yes ___ No ___

Are you currently under a lot of stress? Yes ___ No ___(common stress triggers: job loss, new job, wedding, death in the family or close friend, graduation, long commute, heavily scheduled)

Do you use birth control pills, shots or use an IUD? Yes ___ No ___

If so, which do you use? _____ What brand of pill? _____

Are you pregnant or nursing? Yes ___ No ___

Do you have shaving irritation on your face? Yes ___ No ___

What type of razor do you use for shaving (i.e, double blade, triple blade, rotary) _____

DIET – DO YOU CONSUME THE FOLLOWING?

FOODS		HOW OFTEN PER WEEK	FOODS		HOW OFTEN PER WEEK
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins/Supplements		
Peanut Butter			Seafood		

Have you ever used any Face Reality Skincare products? Yes ___ No ___

If yes, please list the products: _____

_____

Are you still currently using Face Reality Skincare products? Yes ___ No ___

PRODUCTS CURRENTLY USING – PLEASE PROVIDE PRODUCT NAMES

Cleanser	
Toner	
Serums	
Moisturizers	
Sunscreen	
Mask	
Foundation	
Blush	
Exfoliant (acids, serums, scrubs)	
Acne Medications	
Anything Else?	

OTHER TREATMENTS: WHAT ELSE HAVE YOU DONE FOR YOUR SKIN IN THE LAST 90 DAYS?

TREATMENT	WHEN?	WHERE?
Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us? : _____