

Tell Us About Yourself!

Welcome to Adult & Pediatric Dermatology, PC, Center for Cosmetic Services. Please take a few moments to fill out this questionnaire so that we may better classify your skin concerns and skin type.

Name: _____

Date: _____

Skin Concerns

Please check off any skin concerns:

- | | | | |
|--------------------------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blackheads | <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Discoloration/Red Spots | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sagging Skin | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Unwanted Hair | <input type="checkbox"/> Wrinkles | | |

Other: _____

Are you currently under a Dermatologists care? Yes No

Current Skincare Regimen

I use:

Facial cleanser: _____ Frequency _____

Toner: _____ Frequency _____

Topicals: _____ Frequency _____

Moisturizer: _____ Frequency _____

Sunscreen _____ Frequency _____

Do you wear makeup regularly? _____

Do you apply any of the following to your skin regularly? If so, how often?

Retin A or another topical retinoid: _____ Frequency _____

Salicylic acid: _____ Frequency _____

Alpha or Beta Hydroxy products: _____ Frequency _____

Skincare History

Eye color: _____

Natural hair color: _____

Ethnicity: _____

Moisturizer: _____

When exposed to 30 minutes of direct sunlight, do you typically:

- Always burn Burn, then tan Usually tan,
Occasionally burn Always tan

Do you have a history of skin cancer?

- Yes No

Treatment History

Have you ever been treated with a deep peel or dermabrasion?

- Yes | No

Have you ever had light peels, facials, or other skin treatments?

- Yes | No

Have you ever had cosmetic surgery?

- Yes | No

Do you use skin lighteners?

- Yes | No

Do you use any acne medication?

- Yes | No

Social History

Do you smoke?

- Yes | No

Do you drink alcohol?

- Yes | No

OBGYN

Are you pregnant?

- Yes | No

Are you breastfeeding?

- Yes | No

Are you planning to become pregnant in the next three months?

- Yes | No

At Adult & Pediatric Dermatology, PC, our goal is to design a treatment plan specifically for you. We believe in utilizing the most conservative treatment plan that will best achieve your treatment goals.