

# SAVING FACES

## ACNE AND SKINCARE CLINIC

COMMITTED TO MAKING A DIFFERENCE

### CLIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

#### I. Prescribed, over-the-counter and recreational drugs/medications: (past and present)

Medication	When	How Long	Medication	When	How Long
Antibiotics			Testosterone		
Accutane			Progesterone		
Benzoyl Peroxide			Disufuram		
Cleocin-T			Cyclosporin		
E-mycin-T			Dilantin		
Rein A Cream or Gel			Thyroid Medication		
Tazorac			Lithium		
Differin			Quinine		
Azelex			Isoniazid		
Sulphur			Immuran		
Avita			Danzol		
Androstendione			Gonadotrophin		
Cortisone			Steroids		
Minosine			Marijuana		
Copazone			Cocaine/Speed		

#### II. What else have you done for your skin:

Service	When	Service	When
Glycolic Acid Peels		Skin Cancer Removal	
Microdermabrasion		Facial Waxing	
Chemical Peels		Electrolysis	
Dermabrasion		Laser Hair Removal	
Plastic Surgery		Other:	

**III. Products you are currently using:** (please list product names)

Cleanser:
Toner:
Serums
Moisturizers:
SPF:
Mask:
Foundation:
Blush:
Exfoliant (ex: Glycolic):
Acne Medications:

**IV. Lifestyle considerations:**

1. Have you ever had **any** reactions to any of the above products or anything you have ever put on your face? Yes  No  If yes, which product(s): \_\_\_\_\_  
Describe your reaction: \_\_\_\_\_
2. Please place a check if you are allergic to: Sulphur  Asprin  Latex
3. Do you Smoke? Yes  No
4. Do you use fabric softener or fabric softener sheets in the dryer? Yes  No
5. Do you pick at your skin? Yes  No
6. Do you work around chemicals, tars, oils or inks? Yes  No
7. Are you currently under a lot of stress? Yes  No
8. Please place a check if you regularly eat or ingest:  
Kelp  Seaweed  Sushi  Salt  Fast Foods
9. WOMEN ONLY: Are you on birth control pills? Yes  No  If yes, which brand: \_\_\_\_\_  
Are you taking Dep Provera shots? Yes  No   
Are you pregnant or nursing? Yes  No

**V. Skin care concerns:** (please check all that apply)

- |                  |                          |                     |                          |                    |                          |
|------------------|--------------------------|---------------------|--------------------------|--------------------|--------------------------|
| Blackheads       | <input type="checkbox"/> | Dehydrated Skin     | <input type="checkbox"/> | Dry, Flaky Skin    | <input type="checkbox"/> |
| Whiteheads       | <input type="checkbox"/> | Dark Spots          | <input type="checkbox"/> | Sensitive Skin     | <input type="checkbox"/> |
| Pimples/Pustules | <input type="checkbox"/> | Age Spots           | <input type="checkbox"/> | Razor Bumps        | <input type="checkbox"/> |
| Cysts            | <input type="checkbox"/> | Broken Capillaries  | <input type="checkbox"/> | Shaving Irritation | <input type="checkbox"/> |
| Oily Skin        | <input type="checkbox"/> | Fine Lines/Wrinkles | <input type="checkbox"/> | Acne Rosacea       | <input type="checkbox"/> |

**VI. Describe your skin type:**

- Oily
- Normal
- Dry
- Oily/Dry
- Sensitive

**VII: Medical History:** (please check all that apply)

- |           |                          |                    |                          |                     |                          |
|-----------|--------------------------|--------------------|--------------------------|---------------------|--------------------------|
| Diabetes  | <input type="checkbox"/> | HIV Positive/AIDS  | <input type="checkbox"/> | Lupus               | <input type="checkbox"/> |
| Eczema    | <input type="checkbox"/> | Hormone Problems   | <input type="checkbox"/> | Thyroid Problems    | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | Hysterectomy       | <input type="checkbox"/> | Herpes Simplex      | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | Ovary(ies) Removed | <input type="checkbox"/> | Anemia              | <input type="checkbox"/> |
| Cancer    | <input type="checkbox"/> | Hemophilia         | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |

Are you under a dermatologist's care? Yes  No  If yes, name of doctor: \_\_\_\_\_

**VIII: Miscellaneous:**

1. Occupation: \_\_\_\_\_

2. How did you hear about us: \_\_\_\_\_

**Please return completed questionnaire to:**

**Saving Faces Acne & Skincare Clinic**  
**2 1/2 Beacon Street, 2nd Floor**  
**Concord, NH 03301**

**603-397-2384**

**ww.SavingFacesAcne.com**