Southside Laser and Skin Center

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Skin Questionnaire

Name: _____DOB:_____

Address:_____ City: _____

State: _____ Zip: _____ Primary Phone: _____

Secondary Phone: _____ Email: _____

Emergency contact:_____ Phone:_____

Smoker: Yes/No Pregnant: Yes/No Cosmetic Surgery: Yes/No

If so, what procedure and when? _____

List current medications:

_____

_____

Any chronic health conditions: _____

Allergies to medications or metals: Yes/No If yes, please describe: _____

_____

Do you suntan? Yes/No Do you use sunscreen? Yes/No

Have you ever used Retin-A or Retinol ? Yes/No If yes, what strength and when? _____

Have you ever been treated with Phenol or Trichloracetic Acid (TCA)? Yes/No If yes, when? _____

Have you ever been treated with hydroquinone (skin lightener)? Yes/No

Have you ever been prescribed Accutane? Yes/No If yes, when? _____

Have you ever had herpes, hives, cold sores, or keloid scarring? Yes/No If yes, when?_____

How would you describe your skin? Sensitive, Rough, Dry, Oily, Acne Prone?

What is your biggest complaint about your skin? _____

Any special needs or instructions regarding your care? _____

Patient Signature: _____ Date: _____