DUBLIN FAMILY CHIROPRACTIC

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# Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skin Care Specialist to accurately analyze and assess your skin care needs.

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone _____Cell Phone _____

Work Phone_____ X _____

Email Address _____

Emergency Contact: _____

Phone number: _____Relation:_____

## Health History

What type of work do you do?

_____

Have you seen a dermatologist in the past year? Yes_____No_____

If yes, list dermatologist's name, contact info and reason for visit_____

_____

Are you presently under a physician's care? Yes_____No_____

If yes, list physician's name and reason for visit _____

_____

Are you currently taking any medications? Yes_____No_____ If yes, please list _____

_____

What is your genetic background?_____

How is your general health? _____ Excellent _____ Good _____ Fair _____ Poor

Please rate your stress level from 1-5 (5 being the highest): _____

Please circle the following conditions you have/had experienced:

- •hypertension
- •metal plate
- •diabetes
- •fainting
- •cold sores
- •hernia
- •high/low blood pressure
- •stroke
- •contact lenses
- •anemia
- •lupus
- •irregular pulse
- •claustrophobia
- •cancer
- •thyroid disorders
- •high cholesterol
- •varicose veins
- •seizures
- •eating disorder
- •epilepsy
- •heart attack
- •headaches
- •asthma
- •hepatitis
- •tooth fillings
- •autoimmune disorder

Do you take nutritional supplements? Yes_____ No_____

Do you exercise? Yes_____ No_____

Do you have a tendency to scar? Yes_____ No_____

**Allergies:**
Have you ever had an allergic reaction to any of the following:

ASPIRIN OR SALICYLATES Yes_____ No_____

MILK Yes_____ No_____

APPLES Yes_____ No_____

CITRUS Yes_____ No_____

GRAPES Yes_____ No_____

INGREDIENTS IN SKIN CARE PRODUCTS Yes_____ No_____

FISH, MARINE OR IODINE ALLERGIES Yes_____ No_____

LATEX Yes_____ No_____

If checked yes to any of the above, please explain _____

_____

Please list any other known allergies:_____

Have you ever had Herpes Simplex? Yes_____ No_____

If yes, have you ever been treated with
Denavir® (Penciclovir), Zovirax® (Acyclivor) or Abreva? Yes_____ No_____

Are you being treated for Hepatitis? Yes_____ No_____

**Female clients only:**
Are you on hormone replacement therapy? Yes_____ No_____

Are you presently taking birth control pills? Yes_____ No_____

Are you pregnant or nursing? Yes_____ No_____

# Skin Care History

Are you currently having skin treatments? Yes_____ No_____

If yes, what type of treatment(s) _____

Please check if you are presently using or have used in the past any of the following:

_____ Benzoyl Peroxide (BP)
_____ Glycolic Acid (AHA)
_____ Lactic Acid (AHA)
_____ Resorcinol
_____ Salicylic Acid (BHA)

Do you have or have you had any of the following in the last 14 days?

_____ Facial Cosmetic Surgery
_____ Botox Injections
_____ Collagen Injections
_____ Fillers
_____ Light Treatments
_____ Laser Resurfacing
_____ Microdermabrasion
Other_____

HOME CARE:

What Skin care products are you currently using at home?

Cleanser _____ Vitamin C _____

Toner _____ Exfoliants/Scrubs _____

Moisturizer _____ Specialty Products _____

SPF _____ Mask_____

PRESCRIPTION PRODUCTS:

_____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
_____ Adepalene (Differin®)
_____ Azelaic Acid (Azelex®, Finacea™)
_____ Tazarotene (Tazorac®)
_____ Isotretinoin (Accutane)
_____ Triluma™
_____ Metrogel

Any other topical antibiotics_____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

| | | |
|---|---|---|
| _____ Skin Cancer | _____ Dermatitis | _____ Keloid Scarring |
| _____ Hyperpigmentation | _____ Rosacea | _____ Broken Capillaries |
| _____ Hypopigmentation | _____ Acne | _____ Treatment Reactions |

SUN PROTECTION:

Do you use a sunscreen? Yes_____ No_____
What level of protection? _____
Do you sunbathe or participate in outdoor activities? Yes_____ No_____
Do you tan in a tanning booth? Yes_____ No_____
Have you tanned in a tanning booth in the last 14 days? Yes_____ No_____
Have you had any direct sun exposure in the last 10 days? Yes_____ No_____

WHEN EXPOSED TO THE SUN DO YOU:

_____ Always burn, never tan
_____ Always burn, sometimes tan
_____ Sometimes burn, sometimes tan
_____ Always tan

Do you feel your skin is sensitive? Yes_____ No_____

WHAT SKIN CONDITIONS DO YOU WANT TO IMPROVE?

| | |
|---|---|
| _____ Acne and/or breakouts | _____ Enlarged Pores |
| _____ Facial Scarring | _____ Fine Lines and Wrinkles |
| _____ Hyperpigmentation (freckles, age spots) | _____ Hypopigmentation |

OTHER _____

Is there any other necessary information your Skin Care Specialists should know before beginning your treatment? Yes_____ No_____

If yes, please explain

_____

_____