DERMATOLOGY ASSOCIATES OF WESTERN PENNSYLVANIA

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AESTHETIC QUESTIONNAIRE

Name:____ Date of Birth:___________________

Please circle your response and provide details when appropriate:

Have you had a surgery on your face, neck and/or shoulders within the past 6 months? Yes No
If yes, please explain: ____

In addition to procedures listed above, have you had any surgeries, including plastic surgery within the past year? Yes No
If yes, please explain:____

Have you had any facial piercings, tattoos, or permanent cosmetics? Yes No
If yes, please give location(s):____

Have you received chemotherapy or radiation in the past year? Yes No

Have you been diagnosed with skin cancer? Yes No
If yes, please explain:____

Have you ever had an allergic reaction or sensitivity to any of the following?
Lanolin Latex rubber Vaseline Metals Hair Dyes Lidocaine Paints Glycerine Cosmetics

Have you had or do you currently suffer from any of these health conditions? (Circle all that apply)

Thyroid condition	Epilepsy	Frequent cold sores	Prolonged bleeding	HIV
Hysterectomy	Seizure disorder	Herpes	High blood pressure	Low blood pressure
Varicose veins	Fainting spells	Skin disease/skin lesions	Artificial Heart Valve	Trichotilomania
Hemophilia	Dizziness	Liver disease	Circulatory problems	Diabetes
Hair loss	Fever blisters	Hepatitis	Cancer	Any active infection

Please explain: ____

Within the last three months, have you used Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? Yes No Have you used acne medications? Yes No
If yes, please explain: ____

Are your currently taking or have you taken Accutane within the past 12 months? Yes No
If yes, please explain: ____

Have you had a chemical or laser peel within the past 6 months? Yes No
If yes, please explain: ____

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin), Hypopigmentation (lightening of the skin), or mark easily after physical trauma?
Yes No
If yes, please explain: ____

Do you burn from the sun easily? Yes No

Have you ever had an adverse reaction after using any skin care product? Yes No
If yes, please explain: ____

Do you wear contact lenses? Yes No

How frequently are you exposed to the sun or use a tanning bed (please circle)?
Never Yearly Monthly Weekly Daily

Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes No

Female Clients Only:
Are you taking oral contraceptives? Yes No

Are you pregnant or trying to become pregnant? Yes No Are you lactating? Yes No

I agree that this constitutes full disclosure and understand that withholding information or providing misinformation may result in contraindications and/or irritation from treatments received. I also understand that aesthetic results vary, and payment is required at the time services are rendered.

Signature:____ Date: ___________