



Skin Care Questionnaire

Name: _____ Date of Birth: ____/____/____

Today's Date: _____ Phone: _____ Email: _____@_____

Address: _____

How did you hear us? _____

Do you Sun Tan? Yes No Do you use a tanning bed? Yes No

Do you use a daily sunscreen? Yes No Any history of cold sores? Yes No

Would you characterize your skin as: Sensitive Dry Rough Oily

What are your skin complaints/concerns?

Wrinkles Fine Lines Deep Lines Laxity Loss in Volume Skin Laxity

Frown Lines Double Chin Varicose Veins Spider Veins Acne Scars

Stretch Marks Pigmentation Age Spots Rejuvenation Anti-Aging Hair Loss

Other: _____
