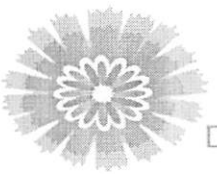

WEST HILLS
DERMATOLOGY

# 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: _____

_____