CLIENT QUESTIONNAIRE - PhotoDerm

Name: _____

MEDICAL INFORMATION:

Do any of the following pertain to you?

NO	YES	DATE	
____	____	_____	Accutane
____	____	_____	Allergies
____	____	_____	Autoimmune disease, HIV, Lupus, Hepatitis
____	____	_____	Birth Control Pills, Hormones
____	____	_____	Diabetes
____	____	_____	Eczema
____	____	_____	Glycolic Treatments
____	____	_____	Herpes, Cold Sores, Fever Blisters
____	____	_____	Irregular, Pigmented Moles or Growths
____	____	_____	Keloids, Pigmented Scars
____	____	_____	Migraine Headaches
____	____	_____	Pregnancy, Breast Feeding
____	____	_____	Retin A, Renova
____	____	_____	Recent sunburn (area being treated)
____	____	_____	Warts (area being treated)
____	____	_____	Smoke
____	____	_____	Any condition not listed: _____
____	____	_____	Currently under the care of a physician?
____	____	_____	Currently taking any medication? _____
____	____	_____	Previous laser procedures, chemical peel, dermabrasion or Microdermabrasion?

In doing PhotoDerm, my interest is primarily for (skin rejuvenation, acne, hyper pigmentation, roseacea, etc.): _____

_____

Specific areas of concern: (eyes, mouth, forehead, nose, chest) _____