



CIRCADIA

by Dr. Pugliese

Advanced Professional Skincare

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PLEASE PRINT

Today's Date _____

First Name _____ Last Name _____ Date of Birth ____/____/____

Street _____ Apt. # _____ City _____ State _____ Zip _____

Phone – Home () _____ Work () _____ Mobile () _____

Dermatologist/physician _____ Phone () _____

Emergency Contact _____ Phone () _____

Your occupation _____ E-Mail _____

Referred by ☐ Friend ☐ Mailer ☐ Walk-by ☐ E-mail ☐ Gift Certificate ☐ Other _____

Skin Care Professional Name: _____

1. What is the reason for your visit today? _____

2. What special areas of concern do you have? _____

EXPECTATIONS and HISTORY

3. Which conditions would you like to improve?

- | | |
|--|--|
| <input type="checkbox"/> Acne scarring | <input type="checkbox"/> Hyperpigmentation |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Broken capillaries |
| <input type="checkbox"/> Age spots | <input type="checkbox"/> Stretch Marks |
| <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Surgical/facial scars |
| <input type="checkbox"/> Fine lines & wrinkles | <input type="checkbox"/> Other _____ |

4. Have you ever had facial treatment in the past? ☐ Yes ☐ No

5. What was your experience? _____

6. How would you describe your skin?

☐ Normal ☐ Dry ☐ Oily ☐ Combination ☐ Sensitive ☐ Sun Damaged

7. How would you rate your skin? (Circle one)

- I Always burns, never tans
- II Always burns easily, tans slightly
- III Burns moderately – tans gradually
- IV Seldom burn – Always tans well
- V Rarely burns – Deep tan
- VI Never burns – Deeply pigmented

8. Do you ever experience ☐ Flakiness? ☐ Tightness?
☐ Redness? ☐ Excessive oily shine during day?

9. What is your present skin regimen?

- ☐ Soap & water only ☐ Cleanser ☐ Toner ☐ Masque
☐ Moisturizer ☐ Exfoliation ☐ Sun Block every day
Other _____

10. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?

- ☐ Yes ☐ No

If yes, what are they? _____

11. Do you blush easily? ☐ Yes ☐ No

If yes, what are the contributing factors?

- ☐ Emotions ☐ Foods ☐ Temperature changes ☐ Other _____

12. Do you ☐ Sun bathe? ☐ Use a tanning bed? How often? _____

13. Have you ever had ☐ Peels? ☐ Microdermabrasion ☐ Facial surgery
☐ Cosmetic Surgery ☐ Botox ☐ Collagen Injections ☐ Laser resurfacing
How recently? _____

14. Are you under treatment for any current skin condition? ☐ Yes ☐ No

If yes, what? _____

15. Does your skin heal ☐ Fast? ☐ Scars? ☐ Pigments?

16. Do you bruise easily? ☐ Yes ☐ No

17. Do you get sores/blisters (Herpes Zoster/Shingles)? ☐ Yes ☐ No

18. What medications/hormone replacement/vitamins do you presently take?

19. Have you ever used ☐ Accutane® ☐ Retin-A® ☐ Renova®

☐ Topical Antibiotics ☐ Differin ☐ Tazarac ☐ Hydroquinone ☐ Alpha Hydroxy Acids?

If yes, when and for how long? _____

20. Any personal or family history of skin cancer? ☐ Yes ☐ No

Provide detail _____

21. How would you describe your overall health?

- ☐ Excellent ☐ Good ☐ Fair ☐ Poor

22. Have you had any of the following, past or present?

Acne	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Arthritis or Bursitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Blood Pressure	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Breast Implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cholesterol	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Claustrophobic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Diarrhea/constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where _____
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often _____
Heart Disease/Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What _____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Menopausal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pace Maker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Phlebitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Serious Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What _____
Sleep problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Normal
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you wear contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

23. Have you ever had a reaction to ☐ Cosmetics ☐ Metals ☐ Medication ☐ Food
☐ Fragrance ☐ Airborne particles? ☐ Other Explain _____
24. **FOR WOMEN:** Oral contraceptives? ☐ Yes ☐ No
 Are you pregnant or trying to get pregnant? ☐ Yes ☐ No
 Are you taking hormone replacement? ☐ Yes ☐ No
 Do you experience hormone imbalances? ☐ Yes ☐ No
25. **FOR MEN:** Do you shave with ☐ Electric shaver? ☐ Razor?
 Do you experience skin breakouts? ☐ Yes ☐ No
 Do you have ingrown hair? ☐ Yes ☐ No

LIFESTYLE & DIET

- Is your stress level ☐ High ☐ Medium ☐ Low
- Do you normally sleep well? ☐ Yes ☐ No
- Do you regularly exercise? ☐ Yes ☐ No
- Do you have food intolerances? ☐ Yes ☐ No What? _____
- Do you follow any special diet? ☐ Yes ☐ No
- How many glasses of water do you consume daily? _____
- How many cups of caffeine-type beverage (coffee, tea, soft drinks) do you consume daily?
☐ 1-3 cups ☐ 4 or more
- In our treatment program, it may be necessary to recommend alterations to or additions in your home care regimen; would that be OK with you? ☐ Yes ☐ No

Your practitioner will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

INFORMED CONSENT RELEASE

I _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care professional will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may

obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will inform my skin care professional immediately.

I release and hold harmless the skin care professional [insert your name], [insert business name], and the staff harmless from any liability for adverse reactions that may result from this treatment.

POLICIES

1. We require 48-hours notice for cancellations. Cancellation for Monday must be phoned in on the Friday before.
2. If you are not satisfied with your service or products, please contact your skin care professional within 24-hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information _____ Date _____
Client Signature