



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?

- Acne scarring
- Acne
- Age spots
- Enlarged Pores
- Fine lines & wrinkles
- Hyperpigmentation
- Broken capillaries
- Stretch Marks
- Surgical/ facial scars
- 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