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Skin Restoration Questionnaire

In order to provide you with the most appropriate skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

Your Personal Information:

Last Name: _____ First Name: _____

Current Date: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Preferred contact number: _____

Home Number: _____ E-Mail Address: _____

Emergency Contact Name and Phone: _____

How were you referred to us? _____

Your Medical Information:

Do you have any of the following medical conditions? (Please check all that apply)

____ Cancer ____ Diabetes ____ High blood pressure ____ Herpes ____ HIV / AIDS

____ Frequent cold sores ____ Keloid scarring ____ Skin disease ____ Seizure disorder

____ Hepatitis ____ Hormone imbalance ____ Thyroid imbalance ____ Arthritis

____ Any active infection ____ Skin lesions ____ Blood clotting abnormalities

Do you have any other health problems or medical conditions? Please list:

Are you currently taking any medications? Please list:

