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**Skincare History Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Occupation? \_\_\_\_\_

Have you seen a Dermatologist in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list Dermatologist's name and reason for visit \_\_\_\_\_

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

What is your ethnic background? \_\_\_\_\_

How is your general health?

\_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Please rate your stress level from 1-5 (5 being the highest): \_\_\_\_\_

Please circle the following conditions you have or had experienced:

Anemia	Contact Lens	Headaches	Stroke
Asthma	Diabetes	Hepatitis	Thyroid Disorders
Blood Thinner	Eating Disorder	High/Low Blood Pressure	Tooth Fillings
Cancer	Epilepsy	Lupus	Varicose Veins
Claustrophobia	Fainting	Mitral Valve Prolapse	
Cold Sores	Food Disorders	Seizures	

Do you take nutritional supplements? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a tendency to scar? Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies:

Have you ever had an allergic reaction to any of the following?

Milk Yes \_\_\_\_\_ No \_\_\_\_\_

Apples Yes \_\_\_\_\_ No \_\_\_\_\_

Citrus Yes \_\_\_\_\_ No \_\_\_\_\_

Grapes Yes \_\_\_\_\_ No \_\_\_\_\_

Ingredients in skincare products Yes \_\_\_\_\_ No \_\_\_\_\_

Fish, marine or iodine allergies Yes \_\_\_\_\_ No \_\_\_\_\_

Latex Yes \_\_\_\_\_ No \_\_\_\_\_

Please list medication allergies:

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Have you ever had Herpes Simplex (cold sores)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, have you ever been treated with Denavir® (Penciclovir), Zivirax® (Acyclovir) or Abreva? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you being treated for Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_

Female clients only:

Are you on hormone replacement therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you presently taking birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you pregnant or nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

### **Skincare History**

Treatments:

Are you currently having skin treatments? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of treatment (s) \_\_\_\_\_

Have you had any of the following in the last 6 months?

- \_\_\_\_\_ Facial Cosmetic Surgery
- \_\_\_\_\_ Botox Injections
- \_\_\_\_\_ Collagen Injections
- \_\_\_\_\_ Skin Cancer
- \_\_\_\_\_ Dermatitis
- \_\_\_\_\_ Keloid Scarring
- \_\_\_\_\_ Laser Resurfacing
- \_\_\_\_\_ Microdermabrasion
- \_\_\_\_\_ Chemical Exfoliation (Peels)
- \_\_\_\_\_ Extractions (whiteheads, blackheads)
- \_\_\_\_\_ Permanent Cosmetics
- \_\_\_\_\_ Waxing
- \_\_\_\_\_ Laser Hair Removal

Other : \_\_\_\_\_

Home Care:

What skincare products are you currently using at home?

Cleanser \_\_\_\_\_ Vitamin C \_\_\_\_\_

Toner \_\_\_\_\_ Exfoliants \_\_\_\_\_

Moisturizer \_\_\_\_\_ Specialty Products \_\_\_\_\_

SPF \_\_\_\_\_

Please check if you are presently using or have used in the past, any of the following:

- |                             |                            |                     |
|-----------------------------|----------------------------|---------------------|
| _____ Benzoyl Peroxide (BP) | _____ Glycolic Acid (AHA)  | _____ Lactic Acid   |
| _____ Resorcinol            | _____ Salicylic Acid (BHA) | _____ Sulfur        |
| _____ Vitamin A             | _____ Vitamin C            | Hydrocortisone (HC) |
| _____ Hydroquinone (HQ)     |                            |                     |

Prescription products

- |  |                              |
|--|------------------------------|
| _____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita) | _____ Adepalene (Differin®)  |
| _____ Azelaic Acid (Azelex®, Finacea™)                   | _____ Taxzarotene (Tazorac®) |
| _____ Isotretinoin (Accutane)                            |                              |

Sun Protection:

Do you use a sunscreen? Yes \_\_\_\_\_ No \_\_\_\_\_

What level of protection? \_\_\_\_\_

Do you sunbathe or participate in outdoor activities? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you tan in a tanning booth? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you tanned in a tanning booth in the last 14 days? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any direct sun exposure in the last 10 days? Yes \_\_\_\_\_ No \_\_\_\_\_

When exposed to the sun do you:

\_\_\_\_\_ Always burn, never tan

\_\_\_\_\_ Always burn, sometimes tan

\_\_\_\_\_ Sometimes burn, sometimes tan

\_\_\_\_\_ Always tan

Do you feel your skin is sensitive? Yes \_\_\_\_\_ No \_\_\_\_\_

What skin conditions do you want to improve?

\_\_\_\_\_ Acne and or breakouts

\_\_\_\_\_ Facial Scarring

\_\_\_\_\_ Hyperpigmentation (freckles, age spots)

\_\_\_\_\_ Enlarged Pores

\_\_\_\_\_ Fine Lines and Wrinkles

\_\_\_\_\_ Rosacea

\_\_\_\_\_ Uneven Tone

Other \_\_\_\_\_

Is there any other necessary information your skincare specialists should know before beginning your treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge

I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type (s) and conditions (s).

I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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