# Skin Questionnaire

HALL WRYE
PLASTIC SURGEONS & MEDICAL SPA

**Reason for today's visit**

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## Please answer the following questions.

How do you feel about the general appearance of your skin?

◯ Good ◯ Would like some improvement ◯ Don't like the appearance of my skin

How much time do you spend in the sun?

◯ A lot ◯ Some ◯ Very little ◯ Used to spend a lot of time in the sun

Is your skin sun-damaged?

◯ Yes ◯ No

## Please answer the following questions.

How often do you use a tanning booth?

◯ Frequently ◯ Occasionally ◯ Never ◯ Previously used/quit _____

Do you have wrinkles or frown lines you would like to remove?

◯ Yes ◯ No If yes, where? _____ - _____

What is more important to you in your decision to have a physician-administered injectable treatment for lines, wrinkles, or folds?

◯ Results that appear immediately and last 1 year or ◯ Results that take effect over time and last 2 years

Does your skin have red birthmarks?

◯ Yes ◯ No If yes, where? _____

Do you have veins on your legs that bother you?

◯ Yes, painful ◯ Yes, cosmetic only ◯ No

Do you have diffuse redness or small vessels on your face?

◯ Yes ◯ No

Does your face become red when you eat spicy foods, consume alcohol, or get excited?

◯ Yes ◯ No

Do you break out regularly?

◯ Yes ◯ No If yes, where? _____

Do you experience excessive sweating?

◯ Yes ◯ No If yes, where? _____

Do you use a particular line of skincare products?

◯ Yes ◯ No If yes, which product line? _____

Have you ever used skincare products with alpha hydroxy, glycolic acid, retinol, or a hydroquinone?

◯ Yes ◯ No If yes, what strength? _____

Have you had any experience with dermal fillers, injectables, or other types of cosmetic procedures (microdermabrasion, laser treatments, etc.)?

◯ Yes ◯ No If yes, please specify _____

Have you ever had a chemical peel?

◯ Yes ◯ No If yes, when? _____

Do you regularly apply sunscreen?

◯ Yes ◯ Only when outside ◯ Rarely ◯ Never

Do you have problems with healing?

◯ Yes ◯ No

Do you develop keloids (scars) after surgery?

◯ Yes ◯ No

Do you bleed easily?

◯ Yes ◯ No

Do you develop skin rashes in reaction to any of the following? (check all that apply)

◯ Medications ◯ Food ◯ Environment ◯ Other _____

Patient Signature_____ Date_____