

WESTMORELAND DERMATOLOGY ASSOCIATES

Questionnaire for Chemical Peels

Name: _____

Date: _____

Email: _____

Please notify me of upcoming specials and promotions.

1. What are your areas of concern? (Please check all that apply)

- | | | | |
|---|--|--|--------------|
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Clogged Pores | <input type="checkbox"/> Acne | Other: _____ |
| <input type="checkbox"/> Excessive Oiliness | <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Blackheads | _____ |
| <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Freckles | _____ |
| <input type="checkbox"/> Dry Patches | <input type="checkbox"/> Scarring | <input type="checkbox"/> Uneven skin color | _____ |

2. Are you using any of the following? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Glytone | <input type="checkbox"/> Zovirax | <input type="checkbox"/> Retin A/Differin/Renova/Tretinoin (how long? _____) |
| <input type="checkbox"/> Azelex | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Hydroquinone |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Accutane (Check yes if used within the last 6 months.) | |

3. Please list your current skincare regimen.

Cleanser: _____	Eyecream: _____
Toner: _____	Sunscreen: _____
Moisturizer: _____	Others: _____

4. Do you have any chronic or medical disorders?

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Other: _____ |

5. Have you ever experienced an allergic reaction to any medications or cosmetic ingredients?

- Yes If yes, please explain: _____
- No _____

6. Are you pregnant or actively trying to become pregnant?

Yes No

7. Sun Exposure:

Past: Little Moderate Excessive

Present: Little Moderate Excessive

8. Tanning Beds:

Past: Little Moderate Excessive

Present: Little Moderate Excessive

9. Have you had any facial hair removal recently or in the past?

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Threading | <input type="checkbox"/> Dipilatories (Nair etc) |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Vaniqa |

10. What is your skin type?

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Oily |
| <input type="checkbox"/> Normal Combination | <input type="checkbox"/> Acne Prone |

<i>Please select if interested in information on the following:</i>
<input type="checkbox"/> Glytone Skincare Products
<input type="checkbox"/> Botox/Dysport
<input type="checkbox"/> Dermal Fillers (e.g. Restylane, Juvederm)
<input type="checkbox"/> Latisse
<input type="checkbox"/> Tattoo Removal
<input type="checkbox"/> Laser Resurfacing (Scarring, Wrinkles)
<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Laser for Redness or Vascular Lesions
<input type="checkbox"/> Laser Removal for Brown Spots