Alexis Dougherty, Inc CaSkin2016@gmail.com **805-687-5538**

Health Questions-*please answer questions and circle Yes, No, OR Don't Know*

1. Present Problem? (bump, rash, etc)
2. How long have you had it?
3. Please describe previous skin problems

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4. Have you been diagnosed with melanoma? *Yes No Don't Know*
5. Has anyone in your family had melanoma? *Yes No Don't Know*
6. Have you had a blistering sunburn? *Yes No Don't Know*
7. Do you use sun-protection regularly?(hat, sunscreen etc) *Yes No Don't Know*
8. How much sun exposure did you have as a child? *Little Moderate Extensive*
9. Does anyone in your family have eczema or asthma *Yes No Don't Know*
10. Have you had an allergic reaction to medications? (pills or shots) *Yes No Don't Know*

    Medications Allergies:
11. What medications do you take?

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12. Do you smoke or use tobacco? *Yes No*
13. How much alcohol do you drink each week
14. Have you been diagnosed with any of the following?:

Basal Cell Skin Cancer	*Yes No*	Genital Herpes	*Yes No*
Squamous Cell Skin Cancer	*Yes No*	Positive HIV test	*Yes No*
Pre-Skin Cancers	*Yes No*	Hepatitis	*Yes No*
Asthma	*Yes No*	Emotional or Mental Illness	*Yes No*
Heart Problems	*Yes No*	Other Cancer	*Yes No*
Diabetes	*Yes No*	Pacemaker	*Yes No*
Hives	*Yes No*	Elevated Blood Pressure	*Yes No*
Allergies	*Yes No*	Kidney Problems or Dialysis	*Yes No*
Cold Sores (Herpes)	*Yes No*	Other Serious Illness	*Yes No*

Please Answer Questions on next page if you're being treated for Acne.

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Acne Questions-*please answer questions and circle Yes, No, OR Don't Know*

1. How long have you had acne?
2. Have you even been treated by a doctor for your acne? *Yes No Don't Know*
3. Have you even been prescribed medication for your acne? *Yes No Don't Know*
4. Do you use sun-protection regularly?(hat, sunscreen etc) *Yes No Don't Know*
5. Does your Acne stress you out OR make you depressed? *Yes No Don't Know*
6. Have you used or taken any of the following?:

Benzoyl Peroxide wash	*Yes No*	Doxycycline, Minocycline pills	*Yes No*
ProActive Kit	*Yes No*	Birth Control Pills	*Yes No*
Salicylic Acid Wash	*Yes No*	Spironolactone Pills	*Yes No*
Neutrogena Acne Wash	*Yes No*	Accutane, Isotretinoin pills	*Yes No*
Stridex or Clearasil Pads	*Yes No*	Other Pills	*Yes No*
Retin-A, Tretinion, Adapalene	*Yes No*	Facialist Treatments	*Yes No*
Clindamycin gel	*Yes No*	Chemical Peels	*Yes No*
Mud Masks	*Yes No*	Laser or Light Treatment	*Yes No*
Witch-hazel, Astringents	*Yes No*	Other Treatment by doctor	*Yes No*

The following questions are for adult women ONLY

1. Are you pregnant? *Yes No Don't Know*
2. Are you planning on getting pregnant in the next 6months? *Yes No Don't Know*
3. Are you breast-feeding? *Yes No*
4. Are you prone to chronic vaginal yeast infections? *Yes No Don't Know*
5. What facial cosmetics do you use?