

## Skin Questionnaire



*Dr. Shel*  
WELLNESS & MEDICAL SPA

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Marital Status: M W D Sp S Occupation: \_\_\_\_\_  
Primary Reason for Visit: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Please check all exposures:

- |   |  |
|---|--|
| <input type="checkbox"/> Previous Laser Treatment | <input type="checkbox"/> Pregnant                  |
| <input type="checkbox"/> Permanent Makeup/Tattoo  | <input type="checkbox"/> Acne                      |
| <input type="checkbox"/> Keloid Scarring          | <input type="checkbox"/> Smoker                    |
| <input type="checkbox"/> Photosensitivity         | <input type="checkbox"/> Alcohol Use               |
| <input type="checkbox"/> Skin Cancer              | <input type="checkbox"/> MVP/Mitral Valve Prolapse |
| <input type="checkbox"/> Hyper/Hypo Pigmentation  |  |
| <input type="checkbox"/> Tanning Booth            | Last exposed _____                                 |
| <input type="checkbox"/> Prior Botox/Fillers      | Last treatment _____                               |
| <input type="checkbox"/> Accutane Usage           | Last usage _____                                   |
| <input type="checkbox"/> Cold sore/Herpes         | Last breakout _____                                |

Drug Allergies \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Medications & over the counter supplements \_\_\_\_\_

### Are you interested in our other services?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Nutritional testing | <input type="checkbox"/> Cellulite Treatment | <input type="checkbox"/> Weight Management   |
| <input type="checkbox"/> Botox Cosmetic®     | <input type="checkbox"/> Chemical Peel       | <input type="checkbox"/> Massage Therapy     |
| <input type="checkbox"/> Dermal Fillers      | <input type="checkbox"/> Laser Hair Regrowth | <input type="checkbox"/> Hormone Replacement |

### Fitzpatrick Scale

\_\_\_\_ I always burn (I) \_\_\_\_ I usually burn (II) \_\_\_\_ I sometimes burn (III)  
\_\_\_\_ I rarely burn (IV) \_\_\_\_ I never burn "brown" (V) \_\_\_\_ I never burn "African American" (VI)