New Client Questionnaire

Name: ____

Date: ____

Areas of concern:
List most important to least important.

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Are you displeased with aesthetic appearance of your facial features?

YES / NO

What type of skin care are you using now to protect and maintain your skin?

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Have you had Fillers, Botox or Lasers in the last 7 days?

YES / NO

Have you ever had any side effects after an injection?

YES / NO

Do you have any hypersensitivity/allergy to any of the ingredients present in injectable products (hyaluronic acid, vitamins, lidocaine, botulinum toxin, etc.)?

YES / NO

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Ever had side effects from microneedling or other similar procedure?

YES / NO

Do you suffer from epidermal reactions, herpetic or infectious types (herpes, acne, etc.)?

YES / NO

Have you ever taken oral retinoids (Isotretinoin) or Accutane within the last year?

YES / NO

History of Chemo/Radiation, Vitiligo, Psoriasis, or any Autoimmune disease?

YES / NO

Are you currently receiving any medical treatment (i.e., aspirin, warfarin, or any other anticoagulant, aminoglycoside antibiotics)?

YES / NO

Are you pregnant or breastfeeding?

YES / NO

Do you smoke?

YES / NO

Do you have any scarring problems?

YES / NO

Do you have any allergies (asthma, allergies to certain medications, food, cosmetics, latex, etc.)? If yes, list which ones.

YES / NO

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Do you suffer from an autoimmune disease or one that affects the immune system?

YES / NO