POMPERAUG PLASTIC SURGERY
SKIN CARE QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

How did you hear about us? _____

Please check if you are presently using any of the following:

☐ Retin-A
☐ Glycolic Acid
☐ Salicylic Acid
☐ Accutane
☐ Topical Vitamin C
☐ Hydroquinone

What skin care products are you currently using? _____

Please check any conditions you wish to improve.

☐ Hyper pigmentation
☐ Acne
☐ Acne Scarring
☐ Sun Damage
☐ Fine Lines
☐ Rough Texture
☐ Black Heads
☐ White Heads

What goals do you hope to achieve? _____

Please check if you have had any of the following procedures or conditions.

☐ Cosmetic Surgery
☐ Botox
☐ Restylane
☐ Chemical Peels
☐ Microdermabrasion
☐ Skin Cancer
☐ Dermatitis
☐ Laser Resurfacing
☐ Keloid Scarring
☐ Rosacea

Do you have any allergies? If yes, please specify _____

Do you use sunscreen daily? ☐ Yes ☐ No Do you use a tanning bed? ☐ Yes ☐ No

Have you ever had a cold sore? ☐ Yes ☐ No Are you pregnant or nursing? ☐ Yes ☐ No

Any medical conditions we should know about? _____

Do you smoke? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No

Please list medications you are currently taking _____

Patient Signature: _____ Date: _____