THE SKIN WELLNESS CENTER

Patient Name: _____ Date: _____ Chart #: _____

Does severe acne run in your family?	Yes/No
Do you have acne on the chest, back, neck, or arms?	Yes/No
Do you participate in athletics or a work-out program?	Yes/No
Do you have a job or hobby that exposes you to a greasy environment or causes a lot of sweating?	Yes/No
Do you have any food allergies?	Yes/No
Do you take any vitamins or health food supplements?	Yes/No
Do you have any menstrual abnormalities?	Yes/No
What type of birth control do you use? _____	
What acne medications have you used previously?	Yes/No
Prescriptions _____	
Over the counter _____	
Do you have "sensitive skin"?	Yes/No
Do you pick?	Yes/No
Are you exposed to cutting oils, solvents, or other harsh chemicals at work?	Yes/No
Do you regularly visit an aesthetician?	Yes/No

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date