DERMATOLOGY
OF NEW MEXICO

610 Broadway Blvd NE, ABQ, NM 87102
Phone: (505) 225-2500
Fax: (505) 225-2025

Esthetician Pre-Procedure Questionnaire

Patient Name:_____ Date of Birth:_____

Date: _____

Reason for today's visit:
_____

Have you ever had chemical peels, laser, microdermabrasion, facials, or extractions in the past? If so, please list which treatments, when and what was your response?
_____

_____

What would you like to achieve from your treatment today?
_____

How did you hear about us? _____

Referred by: _____

Are you allergic to any medications? YES NO
If so, please name: _____
Are you allergic to any cosmetics, personal care products, sunscreens, alpha hydroxy acids, or fragrances? YES NO
If so, please name: _____

When you are exposed to sun do you?
1) Tan only 2) Mostly Tan, But Sometimes Burn 3) Mostly Burn, But Sometimes Tan 4) Always Burn

Have you been in the care of a dermatologist within the last year? YES NO
If yes, please explain: _____

Have you ever had skin cancer? YES NO

List any other skin disease or medical condition we should know about:
_____

_____

List any cosmetic or facial surgical procedures you have had in the last 6 months:
_____

Do you have a history of Cold sores around the mouth or nose? YES NO
If yes, what have you taken for this?_____

Are you pregnant? YES NO Do you smoke? YES NO

Signature of Patient_____

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Do you bleed or bruise easily? YES NO Do you take Aspirin or Blood thinners? YES NO

Do you have artificial joint(s)? YES NO

Do you use Retin-A, tretinoin, Renova, Adapalene, Differin, Glycolic Acid, tazorotene other Alpha Hydroxy Acid, Salicylic Acid, LHA or Retinol/vitamin A derivative products? YES NO
If Yes describe:

Have you used any of these products in the last week? YES NO

Have you used ACCUTANE/ISOTRETINOIN in the past? YES NO
If Yes, when?

Do you form thick or raised scars from trauma? YES NO

Do you have Hyperpigmentation (darkening of the skin) after physical trauma? YES NO
Do you have Hypopigmentation (lightening of the skin) after physical trauma? YES NO

Do you consider your skin sensitive? YES NO

List your daily consumption of: Water_____ Caffeine: _____ Alcohol: _____

What skin care products do you currently use?
For face:_____
For eyes:_____
For body:_____

Please circle any skin concerns that may apply:

acne/breakouts	blackheads/whiteheads	excessive oil/shine	rosacea
broken capillaries	redness/ruddiness	brown spots	dry skin
uneven skin tone	wrinkles /fine lines	dull dry skin	acne scars
eye wrinkles/puffiness	cracked/chapped lips	ingrown hairs	

What SPF sunscreen do you use? _____

What other Anti-aging or Cosmetic services are you interested in?

Botox	Fillers	Microneedling	Microdermabrasion	Extractions
Chemical peels	Laser Treatment for: skin tightening, pigmentation, vessels, or hair reduction			PRP

What anti-aging or cosmetic products are you interested in?

Cleansers	Moisturizers	Antioxidants Serums	Sunscreens
Discoloration Serum	Anti-Aging Creams	Eye Creams	Toners

Signature of Patient_____