MOTAKEF PLASTIC + RECONSTRUCTIVE SURGERY

SKIN CARE CONSULTATION QUESTIONNAIRE

1. What concerns do you have about your skin? _____

2. Have you ever used Accutane (Acne Drug)? Yes _____ No _____

3. Are you currently on a restricted diet? Yes _____ No _____

4. What is your ethnic origin? _____

5. Are you taking oral contraception? Yes _____ No _____ What kind? _____

6. Are you pregnant or are you trying to become pregnant? Yes _____ No _____ N/A_____

7. Are you due for your menstrual period within this next week? Yes _____ No _____ N/A_____

8. Do you have regular exercise and sleep patterns? Yes _____ No _____

9. Do you use Retin-A? Yes _____ No _____

10. Do you tan? Yes _____ No _____

11. Do you tan evenly? _____ Blotchy? _____

12. Have you had a chemical peel? Yes ___ No _____

13. What skin care products are you currently using?_____

14. Are you troubled by a breakthrough oily shine during the day? Yes _____ No _____

15. Do you ever experience a skin breakout, and if so, how often? Yes _____ No _____

16. How much plain water do you consume daily? _____ Glasses

17. Do you take any laxatives or diuretics? Yes _____ No _____

18. Do you ever experience any flaking or tightness of your skin? Yes _____ No _____

19. If you sunbathe, do you use a protection on your skin? Yes _____ No _____

20. Do you burn easily in moderate sunlight? Yes _____ No _____

21. Do you blush easily when nervous? Yes _____ No _____

22. Do you have a tendency to redness? Yes _____ No _____

23. Have you ever suffered any sinus problems? Yes _____ No _____

24. Do you take any stimulants or slimming tablets? Yes _____ No _____

25. Do you consider your pain threshold low, medium, or high? _____

26. Do you prefer a massage to be firm or light pressure? _____

27. Have you ever had a reaction to a stimulus such as: (please check)

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_____ Cosmetic _____ Foods _____ Pollen _____

_____ Metals _____ Animals _____ Other (please list) _____