Anna Rosinska M.D.
3316 Andrews Hwy
Midland, TX 79703
(432) 688-1900
www.AskDrAnna.com

NAME_____ **AGE**_____ **DATE**_____

Skin Care Questionnaire

Please choose up to 3 skin care issues that you would like help with:

- □ Clear up acne eruptions
- □ Clear up blackheads
- □ Minimize size of pores
- □ Decrease oiliness of the skin
- □ Lighten acne scarring
- □ Diminish the appearance of capillaries on the face
- □ Decrease redness of the face
- □ Lighten skin complexion or excess pigmentation areas
- □ Restore skin elasticity & firm sagging skin
- □ Hydrate the skin
- □ Smooth skin texture
- □ Diminish flakiness of the skin
- □ Diminish wrinkles and fine lines
- □ Improve dark under eye shadows & under eye puffiness
- □ No special results, just a regimen for my skin

What 3 things would you most like to change about your skin? _____
_____
_____

How much time are you willing to devote to your skin in the morning and evening and weekly?
_____

Skin Quality

Which of the following most closely describes your skin type:

- □ Very fair skin that always burns and never tans. (**Type I)**
- □ Fair skin that always burns and sometimes tans. **(Type II)**
- □ Medium skin that sometimes burns and always tans. (**Type III)**
- □ Olive/light brown skin that rarely burns and always tans. (**Type IV)**
- □ Brown skin that never burns and always tans. (**Type V)**
- □ Dark brown or black skin that never burns and always tans. (**Type VI)**

What is your Ethnicity? □ White/Caucasian □ Hispanic □ African/Caribbean
□ Indian/Pakistani □ Asian □ Native American
□ Mixed Ethnic Background □ Other_____

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Do you have any relative of different ethnicity than yourself? □ Yes □ No
If so, which ethnicity_____

What type of skin do you have? □ Dry □ Normal to Dry □ Normal □ Normal to Oily □ Oily

Facial Lines: □ A few or none □ Some around the eyes
□ Around the eyes and on the face □ Around lip area

Deep creases or folds: □ Between eyebrows □ Nasolabial folds □ Marionette lines

Do you have eye area puffiness? □ No □ Occasionally □ Frequently
Do you have dark under eye shadows? □ Seldom □ Occasionally □ Frequently

Your skin texture is: □ Bumpy and uneven □ Smooth and soft □ Coarse and grainy
Skin thickness: □ Very thick □ Normal □ Very thin

Do you have blackheads? □ Few or none □ Some, especially in the T-zone □ Problem
Your skin pore size: □ Enlarged all over □ Some enlarged in the T-zone □ Nearly invisible

Do you have small red broken capillaries that show through your foundation?
□ None □ A few □ Problem (nose/cheeks/chin)

Does your skin have dry patches? □ Never □ Occasionally □ Frequently
Is your skin extremely dry? □ Yes □ No

Are you susceptible to cold sores? □ Yes □ No

FEMALE: Are you taking oral contraceptive? □ Yes □ No
Are you pregnant, trying to become pregnant, or breast feeding? □ Yes □ No

MALE: Do you ever experience irritation form shaving? □ Yes □ No
Do you experience ingrown hair? □ Yes □ No

Skin Care History

What products are you currently using (include brand) of Skincare, Skin Products, Makeup, Shampoo/Conditioner: _____
_____
_____

What results are you experiencing with these products?_____
_____
_____

How often do you cleanse your face? □ Once daily □ Twice daily

BodyFocus
Laser & Longevity Center

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How often do you exfoliate? □ Never □ Few times a month □ 2-3 times weekly □ Daily

Have you ever had an allergic reaction to skin products? □Yes □ No
What products did you react to? _____

Are you using Glycolic Acid products? □Yes □ No. If so, glycolic acid %: □ 5 □ 10 □ 15 □ 30
Have you ever had professional glycolic acid treatment? □Yes □ No. If so, how often: _____

Have you ever had a chemical peel? □ Yes □ No. If so, how often:_____

Please list any medications you take or any topical treatments you use: _____
_____
_____

Have you ever used acne drug Accutane? □ Yes □ No. If so, how long ago: _____

Do you use Retin A? □ Yes □ No. If so, what do you use it for: □ Acne □ Fine lines
Do you have irritation, flakiness or sensitivity from Retin A? □ Yes □ No

Have you had laser resurfacing or facial plastic surgery in past 3 months? □Yes □ No
Have you had eyelid surgery in the past? □ Yes □ No
Are you planning to have laser resurfacing or facial plastic surgery soon? □ Yes □ No

Life Style History

Is your diet balanced? □ Mostly □ Sometimes □ Never
Do you take regularly: □ Vitamins □ Antioxidants □ Omega-3 (fish oils)

Do you smoke? □ Yes □ No. Alcohol consumption: □ None □ Low □ Moderate □ High

Do you have physically active lifestyle? □ Sedentary □ Moderate □ Very active

What is your stress level? □ Low □ Moderate □ High
What are your sleeping habits? □ Less than 8 hours □ More than 8 hours

How much plain water do you consume daily? □ 1-4 glasses □ 4-8 glasses □ 8+ glasses

Do you consume more than 2 caffeinated beverages daily? (including tea, coffee, coke, soda, energy drinks, chocolate): □ Yes □ No

How many hours of sun exposure do you get in average week: □ 1-5 □ 6-10 □ 11-15 □ 16-20
Time of the day you are in the sun: □ Between 10am-3pm □ Before 10am & after 3pm

Do you use sunscreen daily? □ Yes □ No. SPF number: □ 8 □ 15 □ 30+

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Anything you would like to add: _____

_____

_____

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Thank you for filling out our Questionnaire!