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Chemical Peel Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, and Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your skin type? (Circle all answers that apply)

Oily Acne-Prone Sun –damaged Mature T-Zone/Combination Dry

Uneven/ Blotchy Hyperpigmented Saggy Firm Large Pores Small Pores

Scarred Wrinkled Cystic Milia Comedones (Black heads) Occasional Acne

Describe your skin tone: Blonde/ Fair Irish/Red Undertones/ Asian/African American/ Hispanic

Is there any chance that you are pregnant now? \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently undergone surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, how much and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever have cold sores / fever blisters? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using or have you used in the last year:

 Retin – A \_\_\_\_\_\_\_\_\_\_ Accutane \_\_\_\_\_\_\_\_\_\_

Do you tend to develop keloids? Yes/No

Do you develop post-inflammatory hyperpigmentation? Yes/No

Do you have any immunocompromising conditions? Yes/No What type?\_\_\_\_\_\_\_\_\_\_\_