Blue Laser Light Acne Therapy

Questionnaire

NAME: ____

ADDRESS: ____

CITY: ______________________ STATE: _____ ZIP: __________

Date of Birth: ____________________

Daytime Phone #: ________________

Evening Phone #: ________________

Cell Phone #: ________________

How long have you been experiencing acne? ________________

Are breakouts normally slight, moderate, or severe? ____________

Please describe today's breakout: slight moderate severe

Are you seeing a dermatologist? _________ Name: ___________

What medications/treatments are you currently taking for acne?

____

For how long? __________________

Have you had previous laser treatment for acne? ______________

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