PATIENT SKINCARE ASSESSMENT

PATIENT'S NAME ____Today's Date ____________________

Date of (DOB)_______________ Email:_______________________ Do you wear contact lenses? Yes No

PERSONAL HISTORY

Are you currently seeing a physician for any reason? Yes No

If yes, explain reason____

Have you ever seen a physician or technician specifically for a skin problem or skincare? Yes No

If yes, when and for what reason?____

Are you currently under any other physician's or technician's care for your skin? Yes No

If yes, detail reason(s) ____

Have you or any family member ever had a skin lesion removed by a physician? Yes No

If yes, who had lesion removed? ________________________Anatomical location of lesion?____________________

Do you have any health problems? Yes No If yes, list____

Do you have any allergies or skin sensitivities? Yes No

If yes, list all allergies/skin sensitivities____

Do you currently take any oral medications (prescriptive pharmaceuticals)? Yes No

(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.)

If yes, list all oral medications____

Do you use any topical medications (prescriptive pharmaceuticals)?

(includes Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

If yes, list all topical medications____

Have you ever taken Accutane®? Yes No

I currently take Accutane: Dosage prescribed______________ Frequency taken____________________

I took Accutane in the past: Date discontinued______________ Dosage/frequency used________________

Have you ever had a "COLD SORE"? Yes No If yes, when was your last cold sore? ______________________

Do you ever use depilatories or waxes on your face? Yes No If yes, when last used? ____________________

Do you smoke?	Yes	No	If yes, how much/often?______________________
Do you consume alcohol?	Yes	No	If yes, frequency/amount______________________
Do you have a healthy diet?	Yes	No	List any dietary concerns______________________
Do you exercise?	Yes	No	If yes, how often?______________ Type(s)______________
Do you take vitamins?	Yes	No	If yes, what type(s)?______________________
Do you drink water?	Yes	No	If yes, how many glasses per day?______________________

For women only:

Do you have regular periods?	Yes	No			
Are you going through menopause?	Yes	No			
Are you trying to become pregnant?	Yes	No	Are you in a fertility program?	Yes	No
Are you pregnant or lactating?	Yes	No	Have you ever been pregnant?	Yes	No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Yes No

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? Yes No

If yes, list products used____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes No

If yes, explain type(s) of exfoliation____

SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? Yes No If no, skip this section.

Microdermabrasion	Yes	No	Date of last procedure	________
Chemical Peel(s)	Yes	No	Type of procedure(s)/date	________
Phototherapy	Yes	No	Type of procedure(s)/date	________
Laser Resurfacing	Yes	No	Type of procedure(s)/date	________
Radiofrequency	Yes	No	Type of procedure(s)/date	________
Dermabrasion	Yes	No	Type of procedure(s)/date	________
Facial Surgery	Yes	No	Type of surgery(s)/date	________

Other procedures/date? ________

Additional comments about above procedure(s) ________

OILY SKIN OR ACNE

Any acne breakout? Blackheads Whiteheads Enlarged Pores Pustules Large pores Cysts

Do you have any history of acne or periodic breakout? Yes No If yes Now? In past?________

Do you only experience breakout during or around your menstrual cycle? Yes No

Do you always have a pimple or some type of breakout? Yes No

Does your skin ever flake or feel tight and dry? Frequently? Occasionally? Very rarely?

Is your skin ever shiny (oily) a few hours after cleansing? Frequently? Occasionally? Very rarely?

How noticeable are your pores? Very? T-zone only? Not very noticeable?

SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.? Yes No

Does your skin ever get flaky or itch? Yes No If yes, is it seasonal or all the time?________

Have you ever been diagnosed with Rosacea? Yes No If yes, when was the diagnosis made?________

Do you have difficulty healing from a cut or burn? Yes No If yes, explain________

Have you ever had keloid scarring? If yes, explain ________

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? Deep wrinkles Crows feet Fine lines Skin Laxity

Have you been treated with: Botox Fillers? If yes, date of last treatment ________

Do you work inside? Yes No Occupation ________

Are your hobbies done mostly outside? Yes No Hobbies ________

In the past (including childhood) did you live in a sun belt? Yes No If yes, where? ________

In the past have you neglected to use a sunscreen when outdoors? Yes No ________

Do you ever use tanning beds? Yes No If yes, when? ________

Do you currently wear a sun protection product all day, everyday? Yes No

Are you willing to wear a sun protection product all day, everyday? Yes No

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?

I Burn **II** Usually Burn **III** Sometimes Burn

IV Rarely Burn **V** Never Burn-"Brown" **VI** Never Burn-"Black"

Is your skin pigmentation (skin discoloration): Even Uneven Birthmark(s) Pregnancy Mask

What is your Ethnicity and Race (heritage)? ________

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1. ________
2. ________

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

Face Neck Chest Back Other

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date: