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MEDICAL SKINCARE ASSESSMENT

PATIENT'S NAME _____ **Today's Date** _____
Date of Birth _____

PERSONAL HISTORY

Do you wear contact lenses? □ Yes □ No

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 M.D. Signature