MEDICAL SKINCARE ASSESSMENT

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