

Skin Evaluation

Name _____ Date _____ Age _____

How can we help you today? _____

How do you want to improve your skin? _____

What is your current skincare routine? _____

Have you ever seen a dermatologist, or other physician for your skin? Y N

If yes, when and why? _____

Do you wear makeup? Y N If so, brand and type: _____

Do you wash your face with: Hot water Warm water Cool water

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Y N

If yes, explain: _____

What topical medications do you use or have you used?

Retin-A® (Tretinoin Retinols) Hydroquinone Skin lighteners

If yes, when? _____ On what area of your body? _____

Other (this includes topical antibiotics, OTC acne remedies, Hydrocortisone, Liquid Nitrogen, etc.):

My hair removal method is:

Wet shaving Dry shaving Waxing Tweezing Depilatories Laser treatments

I will ___ will not ___ tolerate temporary redness.

I will ___ will not ___ tolerate temporary flaking and scaling.

I will ___ will not ___ tolerate temporary scabbing.

Describe your level of commitment:

Willing to spend little time and effort Willing to spend moderate time and effort

Willing to spend good deal of time and effort

Have you previously had:

Chemical Peel? Y N

Type of Peel _____ Date _____

Laser Resurfacing, Dermabrasion, or MicroDermabrasion? Y N

Type/Depth (if known) _____ Date _____

Facial Surgery? Y N

Procedure _____ Date _____

Pigmentation (Fitzpatrick scale):

How do you tan?

I Burn II Usually burn, tan slightly III Sometimes burn, tan easily
 IV Rarely burn, tan easily V Never burn (brown) VI Never burn (black)

Pigmentation: Even Uneven Birthmark Pregnancy mask

What is your nationality (heritage)? _____

Acne:

Do you have any history of acne or periodic breakout? Y N _____

Pimples Whiteheads Blackheads
 Acne scars Cysts Flakiness Enlarged pores

Have you ever taken Accutane®? Y N

If yes, please list dates, dosage and frequency: _____

Do you only experience breakout during or around your menstrual cycle? Y N

Do you always have a pimple or some type of breakout? Y N

Facial wrinkles

Deep wrinkles Crows feet Fine lines None

Have you been treated with Botox/Collagen? Y N Date _____

Skin type

Does your skin ever flake or feel tight and dry? Y N

Is your skin ever shiny a few hours after cleansing? Y N

Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives, etc.)

If so, to what? Cosmetics Fabrics Latex Fragrance Metal Detergents

Other _____

I do ___ do not ___ have environmental exposure to chemicals, oils or other substances that aggravate my skin _____

Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Y N

Vascularity (telangiectasia or broken capillaries):

Nose area Cheek area Chin area Forehead Entire face

Ability to heal

Does your skin appear fragile or burn easily? Y N _____

Do you have any problems healing from a cut or bum? Y N _____

Do you have any health problems? Y N _____

Do you ever use depilatories or waxes on your face? Y N If so, when? _____

Have you ever had a "cold sore"? Y N If so, when? _____

Sun history and lifestyle

Do you work inside? Y N Occupation _____

Are your hobbies done mostly outside? Y N _____

In the past (including childhood) did you live in a sun belt? Y N _____

In the past have you neglected to use a sunscreen when outdoors? Y N _____

Do you ever use tanning beds? Y N If so, when? _____

Do you currently wear a sun protection product all day, everyday? Y N _____

Are you willing to wear a sun protection product all day, everyday? Y N _____

Have you or any member of your family had skin cancer? Y N

If yes, who? _____ Anatomical location: _____

My stress level is: High Medium Low

Do you wear contact lenses? Y N

Patient (Legal Guardian) Signature Date

Witness Signature Date

Recommendations: _____

