

Skin Evaluation as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient _____ Age _____ Birthdate _____

Objectives

How do you want to improve your skin? _____

What specific areas do you want to treat? Face Neck Chest
 Back Hands Forearms Lower Legs Other _____

General Questions

Are you currently under the care of a physician for your skin? Yes No

If yes, why? _____

Have you ever seen a dermatologist for your skin? Yes No

If yes, why? _____

Have you or any member of your family had skin cancer? Yes No

If yes, who? _____ and what anatomical site? _____

Are you pregnant or lactating? Yes No

Have you every used acutane? Yes No

What topical medications do you use or have you used?
 Acne Retin-A Glycolic Acid Other _____

What oral medications have you used or do you currently use?
 Tranquilizer Antibiotics Hormones or Birth Control Diuretics

Hypersensitivity and Fragility

Have you ever had a skin allergy? Yes No

If yes, to: Cosmetics Fabrics Aspirin Rashes Other _____

Free Radical Exposure

Do you smoke? Yes No If yes, how much? _____ per day

Do you consume alcohol? Yes No If yes, how much? _____ per day

Do you have a regular diet? Yes No

Do you exercise? Yes No If yes, how much? _____ per day

Do you take vitamins? Yes No
If yes, what kind? Multi-Vitamin Antioxidant Other _____

Facial Wrinkles: Deep Wrinkles Crows feet Fine lines

Skin Evaluation - Continued

Hormones

- Do you have regular periods? Yes No
- Are you going through menopause? Yes No
- During pregnancy did you ever get hyperpigmentation or masking? Yes No

Pigmentation

- How do you tan? A - Always Burn B - Usually Burn C - Burn then Tan
 D - Usually Tan F - Always Tan
- Pigmentation: Even Uneven Birthmark Pregnancy Mask

Vascularity

- Broken Capillaries: Nose area Cheek area Chin area Forehead Entire face

Acne

- Do you have any history of acne or periodic breakout? Pimples Whiteheads
 Blackheads Enlarged Pores Flakiness Acne Scars

Skin Type

- Does your skin ever flake or feel tight and dry? Often Occasionally Rarely
- Is your skin very shiny a few hours after cleansing? Often Occasionally Rarely
- How often do you experience blackheads or facial blemishes? Often Occasionally Rarely
- How noticeable are your pores? Very T-zone Not very

Ability to heal

- Does your skin appear fragile, burns easily? Yes No
- Do you form thick or raised scarring from a cut or burn? Yes No
- Do you have any health problems? Yes No
- Do you wax or use depilatories on your face? Yes No
- Do you ever get cold sores? Yes No

Sun History and Lifestyles

- What percentage of time do you spend in the sun? Summer _____% Winter _____%
- In the past (including childhood) did you live in a sunbelt and sunbathe? Yes No
- In the past have you neglected to use a sunblock when outdoors? Yes No

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____