MEDICAL SKINCARE ASSESSMENT

Patient's Name _____ Today's Date _____

Date of Birth _____ Do you wear contact lenses? ☐ Yes ☐ No

PERSONAL HISTORY

Y N

☐ ☐ Have you ever seen a physician or technician **specifically for a skin problem or skincare?** If yes, when and for what reason? _____

☐ ☐ Are you currently under any other **physician's or technician's care for your skin**? If yes, detail reason(s)

_____

☐ ☐ Have you ever had a **skin lesion** removed by a physician? If yes, anatomical location? _____

☐ ☐ Do you hove any **health problems**? If yes, list: _____

☐ ☐ Do you hove any **allergies** or **skin sensitivities**? If yes, list: _____

☐ ☐ Do you currently take any **prescription oral medications**? e.g. oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.? If yes, list: _____

☐ ☐ Do you use any **prescription topical medications** e.g. Retin-A®, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel@, Efudex@, Cortisone, etc. If yes, list: _____

☐ ☐ Have you ever taken an **oral retinoid**? ☐ Currently taking - or - ☐ Date discontinued _____

☐ ☐ Have you ever had a "**cold sore**"? If yes, when was your last cold sore? _____

☐ ☐ Do you ever use **depilatories or waxes** on your face? If yes, when last used? _____

☐ ☐ Do you **smoke**?

☐ ☐ Do you consume **alcohol**?

For women only:

☐ ☐ Do you have regular periods?

☐ ☐ Are you going through menopause?

☐ ☐ Are you currently pregnant, trying to get pregnant, or breastfeeding? _____

☐ ☐ During pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"?

SKIN PRODUCT HISTORY

☐ ☐ Do you currently use **skincare products** as a daily regimen? If yes, products used _____

_____

☐ ☐ Have you done any **aggressive exfoliation** to your skin in the last 2 weeks?

If yes, type: _____

_____

Continued on back

SKIN PROCEDURE HISTORY

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

Y N

☐ ☐ **Microdermabrasion** Date of last procedure_____

☐ ☐ **Chemical Peel(s)** Type of procedure(s)/date _____

☐ ☐ **Laser Resurfacing** Type of procedure (s)/date _____

☐ ☐ **Dermabrasion** Type of procedure(s)/date _____

☐ ☐ **Botox or dermal fillers?** Type(s)/date(s) _____

☐ ☐ **Facial Surgery** Type of surgery(s)/date _____

Other procedures/date? _____

OILY SKIN OR ACNE

Do you experience any of the following?

☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large pores ☐ Cysts

☐ ☐ Do you **only** experience breakouts during or around your menstrual cycle?

☐ ☐ Do you **always** have a pimple or some type of breakout?

☐ ☐ 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 redden" when eating spicy food, drinking alcohol, getting angry, or going in the sun, etc.?

☐ ☐ Does your skin ever get **flaky or itch**? If yes: ☐ Seasonally ☐ All the time

☐ ☐ Have you ever been diagnosed with **rosacea**? If yes, when was the diagnosis made?_____

☐ ☐ Do you hove **difficulty healing** from a cut or burn? If yes, explain _____

☐ ☐ Hove you ever had **keloid scarring**? If yes, explain _____

PREMATURELY AGED AND/OR HYPER PIGMENTED SKIN

☐ ☐ Do you hove **facial wrinkles**? D Deep wrinkles D Crows feet D Fine lines D Skin laxity

☐ ☐ Have you been treated with **Botox** or **Fillers**? If yes, type/date of last treatment _____

☐ ☐ Do you **neglect to use sunscreen** when outdoors?

☐ ☐ Do you ever use **tanning beds**? If yes,when? _____

☐ ☐ Are you willing to wear a **sun protection product** all day, every day?

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 ARIEAS DO YOU WANT TO TREAT?

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Other:

PATIENT SIGNATURE DATE PHYSICIAN OR MEDICAL ASSISTANT SIGNATURE DATE