MEDICAL SKINCARE ASSESSMENT

Today's Date: __________________

Name:	Date of Birth:
Employment:	Email:
Home Address:	Business Phone:
Home Phone:	Cell Phone:

Personal History

Are you currently seeing a physician for any reason? Yes No

Is 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? ____

Have you or any family member ever had a skin lesion removed by a physician? Yes No

If yes, who had lesion removed? ___________________________ Location of lesion? ________________

Do you have any health problems? Yes No If yes, list _________________________________

Do you have any allergies or skin sensitivities? ____

If yes, list all ____

Do you currently take any oral medications? Yes No

(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc.)

If yes, list all ____

Do you use any topical medications? Yes No

(includes Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

If yes, list all ____

Have you ever taken Accutane®?

I currently take Accutane®: Dosage prescribed: ________________ Frequency Taken: ___________

I took Accutane® in the past: Date discontinued: ____________ Dosage/Frequency: ______________

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 ____

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	Yes	No	Type/Date _________________________
Phototherapy	Yes	No	Type/Date__________________________
Laser Resurfacing	Yes	No	Type/Date__________________________
Radiofrequency	Yes	No	Type/Date__________________________
Dermabrasion	Yes	No	Type/Date__________________________
Facial Surgery	Yes	No	Type/Date__________________________

Other procedures/dates? ____

Oily Skin or Acne

Any acne breakouts? Blackheads Whiteheads Enlarged Pores Pustules Large Pores Cysts

Do you have any history of acne or periodic breakouts? Yes No

If yes: Now? __________________________ In Past? ______________________________________

Do you only experience breakouts 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? Yes No

Frequently? Occasionally? Very rarely?

Is your skin ever shiny (or oily) a few hours after cleansing? Yes No

Frequently? Occasionally? Very rarely?

How noticeable are your pores? Very? T-Zone Only? Not very?

Sensitive and Intolerant or Dry Skin

Do you “flush or become reddened” when eating spicy food, drinking alcohol, angry, 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 it diagnosed? ________

Do you have difficulty healing from a cut or burn? Yes No If yes, explain _______________

Have you ever had a keloid scarring? Yes No 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 ___________

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 Frequency? _____________________

Do you currently wear sun protection all day, every day? Yes No

Are you willing to wear sun protection 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

VI Never Burn

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: ________________________

Skincare Technician Signature: _______________________________________Date: ___________________