# MEDICAL SKINCARE ASSESSMENT

**Today's Date: _____**

| | |
|---|---|
| Name: | Date of Birth: |
| Employment/Position: | Email: |
| Home Address, State, Zip: | Preferred Phone #: Home, Cell or Business?<br>#: ( )<br>#: ( ) |
| How did you hear about Radiance Medical Spa? | What brings you in today? |
| ***What services are you interested in? Circle all that apply:***<br>Hydrafacial * Dermaplaning * Chemical Peels * Chin Fat Reduction(Kybella) * IPL(Lumecca) * Laser Hair Removal(Diolaze) * Botox * Filler * Latisse * Cosmeceuticals * Makeup * Skin Resurfacing (Fractora) | |

## ***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
(Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)
If yes, list all _____
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: _____
Have you ever had a cold sore? Yes No If yes, when was your last cold sore? _____
Do you ever use depilatories (ex. Nair) or waxes on your face? Yes No
If yes, when last used? _____
Do you smoke? Yes No If yes, how much/often? _____
Do you drink alcohol? Yes No If yes, frequency/amount? _____

Do you eat healthy? 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 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 The Past? _____
Do you only experience breakouts during your menstrual cycle? Yes No N/A
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, every day? Yes No

## *FITZPATRICK SCALE: 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?

_____

_____

What specific skin areas do you want to treat?
Face Neck Chest Back Other _____

**Patient Signature: _____ Date: _____**

**Skincare Specialist Signature: _____ Date: _____**