Patient Skin History

Name: ______________________________ Date: ______________________________

DOB: ______________ E-mail: ______________ @ ______________________________

Have you seen a doctor for skin treatment before? ◯Y ◯N Doctor name ______________________

Have you previously had a chemical peel? ◯Y ◯N Type of peel: ______________ Date: __________

Laser or photo treatments? ◯Y ◯N Type/Depth: ______________________ Date: __________

Facial surgery? ◯Y ◯N Procedure: ______________________ Date: __________

Procedure: ______________________ Date: __________

Procedure: ______________________ Date: __________

Are you pregnant or lactating? ◯Y ◯N If yes, when is your due date? ______________________

Are you actively trying to become pregnant? ◯ Y ◯ N

Have you or are you taking Accutane? ◯Y ◯N

If you have taken Accutane in the past, what date did you stop taking it? ______________

Have you or are you using Retin-A? ◯Y ◯N If yes, what concentration? .1% .05% .025%

If you have used Retin-A in the past, when did you stop using it? ______________________

What other topical medications do you or have you used? ______________________

What oral medications do you or have you used (birth control pills, hormones, antibiotics, etc.)?

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Are you currently using Botox® and/or Juvéderm? ◯Y ◯N If so, where? ______________________

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Hypersensitivity and Fragility

Do you have any skin allergies? ◯Y ◯N

To: ◯Cosmetics ◯Fabrics ◯Aspirin ◯Latex ◯Other:________________

Harmful Free Radical Exposure

Do you smoke? ◯Y ◯N How much?________________

Do you consume alcohol? ◯Y ◯N How much?________________

Do you exercise? ◯Y ◯N How often?________________

Do you use a tanning bed? ◯Y ◯N How often?________________

Do you sunbathe outdoors? ◯Y ◯N How often?________________

Do you take vitamins? ◯Y ◯N Please list:________________

Hormones

Do you have regular periods? ◯Y ◯N

Are you going through menopause? ◯Y ◯N

Did you ever experience hyperpigmentation or masking during pregnancy? ◯Y ◯N

If yes, Where? ________________

Skin Type/Pigmentation (Fitzpatrick Scale)

How do you tan? ◯ Burn Always ◯ Usually Burn ◯ Sometimes Burn ◯ Rarely Burn ◯ Never Burn (Brown) ◯ Never Burn (Black)

Pigmentation: ◯ Even ◯ Uneven ◯ Birth mark ◯Pregnancy Mask

Vascularity

Capillaries: ◯ Nose area ◯ Cheek area ◯ Chin area ◯Forehead

Acne

Do you have a history of acne or periodic breakouts? ◯Y ◯N

◯ Pimples ◯ White heads ◯ Blackheads ◯Enlarged pores ◯ Acne scars ◯ Cysts ◯ Flakiness

Facial Wrinkles

◯ Deep wrinkles ◯ Crow's feet ◯ Fine lines

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Skin Type

Does your skin ever flake or feel tight and dry? ○ Frequently ○ Occasionally ○ Rarely

Is your skin shiny a few hours after cleansing? ○ Frequently ○ Occasionally ○ Rarely

Do you experience blackheads or blemishes? ○ Frequently ○ Occasionally ○ Rarely

How noticeable are your pores? ○ Very ○ Somewhat ○ Not very

Skin Health/Healing

Do you get cold sores or fever blisters? ○ Y ○ N If yes, where & how often? ______________________________

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

Do you ever form thick or raised scarring from a cut or burn? ○ Y ○ N

Do you have any health problems that affect your ability to heal? ○ Y ○ N
If yes, please list: ______________________________

Do you use hot wax or depilatones on your face? ○ Y ○ N
If yes, list where and how often: ______________________________

Do you undergo electrolysis for facial hair removal? ○ Y ○ N

Sun History And Lifestyle

Do you work inside or outside? ○ Inside ○ Outside

Are your hobbies done mostly inside or outside? ○ Inside ○ Outside

In the past, how often did you apply Sunblock before going outdoors? ○ Always ○ Sometimes ○ Never

How often do you currently use a sunblock? (List frequency, SPF and type) ______________________________

Nationality? (optional) ______________________________

Have you or has any member of your family had skin cancer? ○ Y ○ N If yes, where? ______________________________

How do you want to improve or change your skin? ______________________________

What Areas Do You Want To Treat?

○ Face ○ Neck ○ Forehead ○ Eyes

Are you interested in Botox® or Juvéderm? ○ Y ○ N

Comments:

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