MEDICAL SKINCARE ASSESSMENT

Patient's Name_____________________________________ **Date**_____________

Date of Birth___________________ **Do you wear contacts?**_______________

PERSONAL HISTORY

1. Are you currently seeing a physician for any reason? ____Y _____N
If yes, please explain:____

2. Have you seen a physician or technician for a specific skin problem or skincare?
If yes please explain:____

3. Are you currently seeing a physician or technician for your skin?

4. Have you or any family member had a lesion removed by a physician? ____Y ____N
If yes, who had the lesion removed?___________ Anatomical location of the lesion:_____________.

5. Do you have any health problems? ______Y ______N If yes, please list
____

6. Do you have any allergies or skin sensitivities? _____Y ______N
If yes, please list ALL allergies /skin sensitivities: ___________________________________

---

7. Do you currently take any oral medications including oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension? _____Y _____N If yes, please list:

---

8. Do you use any topical medications including Retin-A, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel, Efudex, Cortisone, etc.? _____Y _______N
If yes, please list them:____

9. Have you ever taken oral retinoid? ______Y ______N

If you currently take oral retinoid...Date you began__________ Dosage _________
If you took an oral retinoid in the past...Date you discontinued_________
Dosage _______________

10. Have you EVER had a COLD SORE? ____Y ______N
If yes, when was your last cold sore_________________________.

11. Do you ever use depilatories or waxes on your face? _____Y _____N
If yes, when last used?__________________.

12. Do you smoke? ______Y _______N If yes, how much /often_____________
13. Do you consume alcohol? ______Y ______N If yes, frequency/amt.___________

For Women Only

14. Do you have regular periods? ______Y ______N
15. Are you going through menopause? ________Y _________N
16. Are you trying to become pregnant? _______ Y _________N
Are you in a fertility program? ________Y __________N
17. Are you pregnant or lactating? ________Y ________N
Have you ever been pregnant? _________Y ________N
Did you experience any hyperpigmentation or a "pregnancy mask"? ____Y ____N

SKIN PRODUCT HISTORY

18. Do you currently use skincare products as a daily regime? _____Y ______N
    Please list the products you use:

____

19. Have you ever done any aggressive exfoliation to your skin in the last 2 weeks? If so, please explain the type of exfoliation:____.

SKIN PROCEDURE HISTORY

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

Microdermabrasion ______Y _______N Date of last procedure ____________
Chemical Peels _______Y _______N Type/Date ______________________
Phototherapy ________Y _______N Type/Date______________________
Laser Resurfacing ________Y _______N Type/Date ______________________
Radiofrequency ________Y _______N Type/Date_______________________
Dermabrasion _________Y _______N Type/Date_______________________
Facial Surgery _________Y _______N Type/Date ______________________

OILY SKIN OR ACNE

Any breakouts? ____Blackheads _____Whiteheads _____Enlarged Pores ____Cysts
Do you have a history of acne or periodic breakouts? _____Y _____N Now or in the past?
____

Do you only experience breakout during or around your menstrual cycle? ______Y ______N
Do you ALWAYS have a pimple or breakout? ______Y ________N
Does your skin ever flake or feel tight and dry? ________Frequently ________Occasionally
____________Rarely
Does your skin ever flake or feel tight and dry? _________Frequently __________Occasionally
___________Rarely
Is your skin every shiny (oily) a few hours after cleansing? ________Frequently
___________Occasionally _____________Rarely
How noticeable are your pores? ________Very _________T- Zone ________Not

SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc?
______Y _______N
Does your skin ever get flaky or itch? _____Y _____N If yes, is it seasonal or all the time?
Have you ever been diagnosed with Rosacea? ____Y _____N If yes, when?_______.
Have you ever had keloid scarring? If yes explain________________________________.

PREMATURELY AGED AND HYPERPIGMENTED SKIN

Do you have facial wrinkles? ______Deep _______Crows feet _______Fine lines
__________Skin Laxity

Have you been treated with _______Botox ________Fillers If so, what was the date of your last treatment(s)?
____.

Do you work inside? ______ Yes _______No Occupation___________________.

Are your hobbies done mostly outside? ______Y _____N Hobbies______________.

In the past, including childhood, did you live in a sun belt? _____Y _______N
If so, where?_________________________.

In the past have you neglected to use a sunscreen when outdoors? _____Y ______N

Do you ever use tanning beds? _______Y _________N
Are you willing to wear a sun protection product all day, every day?? ____Y _____N

Fitzpatrick Scale (how your skin reacts to sun exposure) How do you tan?

____I Burn _____I Usually Burn _______Sometimes I Burn
____I rarely burn ______I never burn "brown" ______ I never burn "black"

How is your skin pigmentation (skin discoloration)? _______Even _______Uneven
________Birthmark(s) _________Pregnancy Mask

HOW DO YOU WANT TO IMPROVE YOUR SKIN?
____

WHAT SPECIFIC AREAS TO YOU WANT TO TREAT?
_____ Face _______ Neck ______Chest _______Back ______Other

_____________________________ __________
Patient Signature Date

________________________ ___________
Technician Signature Date