



Skin Assessment

PATIENT'S NAME: _____

DATE: _____

Medical Background

1. Are you currently under the care of a physician for your skin? Y N If yes, why? _____
2. Have you ever seen a dermatologist for your skin? Y N If yes, when & why? _____
3. What *topical* medications do you use or have you used? Retin-A Hydroquinone Flourouracil
(This includes topical antibiotics, OTC acne remedies, hydrocortisone, etc) Other
4. Please list any *oral* medications you currently take (This includes Accutane, hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, nutritional supplements.) _____

5. Do you have any known allergies to anything? Y N
If yes, please list (include all meds, aspirin, food, etc.) _____

6. Do you smoke? Y N How often? _____
7. Do you consume alcohol? Y N How often? _____
8. Do you have a healthy diet? Y N List any dietary concerns: _____
9. Do you exercise? Y N How often? _____
10. Do you 'flush' or 'appear reddened' easily when you eat spicy food, drink alcohol, get angry, go into the sun, etc? Y N
11. Do you have problems healing from a cut or burn? Y N If yes, explain: _____
12. Do you have any health problems? Y N If yes, explain: _____
13. Have you *ever* had a cold sore or a herpes outbreak? Y N If yes, when was the last cold sore? _____
14. Do you suffer from light-induced seizures? Y N
15. Are you taking anticoagulants? Y N
16. Have you or any member of your family had skin cancer? Y N If yes, who? _____ Type: _____
17. Do you wear contact lenses? Y N How often? _____
18. Do you work inside? Y N Occupation: _____
19. Are your hobbies done mostly outside? Y N Hobbies: _____
20. What is your ethnicity and Race (heritage)? _____

For women (questions 21 through 26):

21. Do you have regular periods? Y N
22. Are you going through menopause? Y N

23. Are you pregnant or lactating? Y N
24. Are you trying to become pregnant? Y N
25. Have you ever been pregnant? Y N
26. If yes, did you experience hyperpigmentation? Y N

Facial History

27. Have you ever had:
Facial Surgery, Peels, Laser Resurfacing, Dermabrasion Y N Type: _____ Date: _____
28. Have you ever been treated with Botox or other injectables?
If yes, what areas? _____ Date of last treatment: _____
29. What skin care products do you use daily? _____

30. Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely
31. Is your skin ever shiny a few hours after cleansing? Frequently Occasionally Very Rarely
32. How noticeable are your pores? Very noticeable Noticeable Barely noticeable Not noticeable
33. Do you ever use depilatories or waxes on your face? Y N If yes, when last used? _____
34. Pigmentation: Even Uneven Birthmark Pregonancy Mask/Melasma
35. Vascularity (telangiectasias or broken capillaries): Nose Cheek Chin Forehead Entire Face
36. Facial Wrinkles: Fine lines around the eyes Fine lines around the mouth Forehead lines Deep Wrinkles

Acne

37. Do you have a history of acne or periodic breakout? Y N Pimples White heads Blackheads Cyst
 Enlarged Pores AcneScars Flakiness
38. How often do you experience blackheads or blemishes? Frequently Occasionally Very Rarely
39. Do you *always* break out around your menstrual cycle? Y N
40. How do you tan?
 I Burn II Usually Burn III Sometimes Burn IV Occasionally Burn V Rarely Burn VI Never Burn
41. Does your skin appear fragile or burn easily? Y N If yes, explain: _____
42. Have you ever lived in a hot, sunny environment? Y N Where did you live? _____
43. In the past, have you had more than 10 sunburns? Y N How many? _____
44. Have you ever used a tanning bed? Y N If yes, when? _____
45. Do you currently wear sun protection every day? Y N what product? _____

Patient's Signature: _____

Date: _____

PA's or Aesthetician's Signature: _____

Date: _____