



### Medical Skincare Assessment Form

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Date of Birth

Do you wear contact lenses?  Yes  No

#### PERSONAL HISTORY

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

If 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? \_\_\_\_\_

Are you **currently** under any other physician's or technician's care for your skin?  Yes  No

If yes, detail reason(s) \_\_\_\_\_

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

If yes, who had lesion removed? \_\_\_\_\_ Anatomical location of lesion? \_\_\_\_\_

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

Do you have **any** allergies or skin sensitivities?  Yes  No

If yes, list **all** allergies/skin sensitivities \_\_\_\_\_

Do you currently take **any** oral medications (prescriptive pharmaceuticals?  Yes  No

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

If yes, list all **oral** medications \_\_\_\_\_

Do you use any topical medications (prescriptive pharmaceuticals)?

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

If yes, list all topical medications \_\_\_\_\_

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 used: \_\_\_\_\_

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 pregnant or lactating?  Yes  No  
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask?  Yes  No

Are you in a fertility program?  Yes  No  
Have you ever been pregnant?  Yes  No

### SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen?  Yes  No  
If yes, list products used \_\_\_\_\_

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(s)  Yes  No Type of procedure(s)/date \_\_\_\_\_  
Phototherapy  Yes  No Type of procedure(s)/date \_\_\_\_\_  
Laser Resurfacing  Yes  No Type of procedure(s)/date \_\_\_\_\_  
Radiofrequency  Yes  No Type of procedure(s)/date \_\_\_\_\_  
Dermabrasion  Yes  No Type of procedure(s)/date \_\_\_\_\_  
Facial Surgery  Yes  No Type of surgery(s)/date \_\_\_\_\_

Other procedures/Date: \_\_\_\_\_

Additional comments about above procedure(s) \_\_\_\_\_

### OILY SKIN OR ACNE

Any acne breakout?  Blackheads  Whiteheads  Enlarged Pores  Pustules  Large pores  Cysts

Do you have any history of acne or periodic breakout?  Yes  No If yes, Now? In past? \_\_\_\_\_

Do you only experience breakout 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?  Frequently?  Occasionally?  Very rarely?

Is your skin ever shiny (oily) a few hours after cleansing?  Frequently?  Occasionally?  Very rarely?

How noticeable are your pores?  Very?  T-zone only?  Not very noticeable?

### SENSITIVE, INTOLERANT OR DRY SKIN

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or 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 the diagnosis made? \_\_\_\_\_

Do you have difficulty healing from a cut or burn?  Yes  No Type of procedure(s)/date \_\_\_\_\_

Have you ever had 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 treatment \_\_\_\_\_  
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 If yes, when? \_\_\_\_\_  
Do you currently wear a sun protection product all day, everyday?  Yes  No  
Are you willing to wear a sun protection product 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-"Brown"  VI Never Burn-"Black"

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

\_\_\_\_\_  
Technician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date