

# PATIENT SKIN EVALUATION FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please fill in the following description of your facial complexion. This information is necessary for us to design a customized skin care program for you.

What type of skin do you have?     Normal to Dry     Normal to Oily     Very Oily     Very Dry  
Do you tan?     Easily Tan     Burn then Tan     Burn  
Any chronic skin disorders?     Fever Blisters     Psoriasis     Melasma/Hyperpigmentation  
                                                  Dermatitis     Rosecea     Other \_\_\_\_\_

What medications do you take? \_\_\_\_\_

Do they make you photo-sensitive?     Yes     No

Are you allergic to any medications or cosmetic ingredients?     No     Yes

If yes, please list \_\_\_\_\_

Are you using any of the following?

Retin-A?     Yes     No

If yes, what strength? \_\_\_\_\_ How long? \_\_\_\_\_

Renova?     Yes     No

If yes, what strength? \_\_\_\_\_ How long? \_\_\_\_\_

Accutane?     Yes     No

If yes, what strength? \_\_\_\_\_ How long have you been off? \_\_\_\_\_

Taking any oral/topical antibiotic?     Yes     No

If yes, list \_\_\_\_\_

Do you take Valtrex/Zovirax?     Yes     No

If yes, list reason and how long you've been taking it \_\_\_\_\_

Have you taken Tetracycline?     Yes     No

If yes, what strength? \_\_\_\_\_ How long? \_\_\_\_\_

Do you have any facial scarring?     Yes     No

If yes, what facial region? \_\_\_\_\_

Have you had or planning to have any facial surgery?     Yes     No

If yes, what facial region? \_\_\_\_\_

Any prior cosmetic peels?     Salon     TCA     AHA     Other

If yes, how long ago was last peel? \_\_\_\_\_ Did you see results? \_\_\_\_\_

Pregnant?     Yes     No     Planning

Breast Feeding?     Yes     No

Oral Contraceptives?     Yes     No    Date of last period? \_\_\_\_\_

Hormone Imbalance?     Yes     No

Excessive Hair face/breasts?     Yes     No

Facial hair removal?     Waxing     Laser     Other \_\_\_\_\_

Please complete reverse side

Please check the products you are currently using and list the brand name:

- Cleanser \_\_\_\_\_
- Soap \_\_\_\_\_
- Night Moisturizer \_\_\_\_\_
- Antioxidants \_\_\_\_\_
- Exfoliant \_\_\_\_\_
- Facial Mask \_\_\_\_\_

- Toner \_\_\_\_\_
- Day Moisturizer \_\_\_\_\_
- Eye Cream \_\_\_\_\_
- Skin Lightener \_\_\_\_\_
- Sunscreen \_\_\_\_\_
- At Home Peels \_\_\_\_\_

Please list/check any skin conditions you are concerned about:

- Sun Damage
- Freckles
- Clogged Pores
- Dry Patches
- Lip Lines - \_\_\_\_\_ Deep \_\_\_\_\_ Fine
- Pimples/Breakouts - \_\_\_\_\_ Frequently \_\_\_\_\_ Sometimes
- Other concerns: \_\_\_\_\_
- Brown Spots
- Blackheads
- Acne
- Hard Bumps Under Skin
- Wrinkles - \_\_\_\_\_ Deep \_\_\_\_\_ Fine
- Splotched, uneven skin color
- Whiteheads
- Excessive Oiliness
- Visible facial spider veins/capillaries

OFFICE NOTES:

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Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_