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
○ Brown Spots
○ Blackheads
○ Acne
○ Hard Bumps Under Skin
○ Splotched, uneven skin color
○ Whiteheads
○ Excessive Oiliness
○ Visible facial spider veins/capillaries
○ Lip Lines - _____ Deep _____ Fine
○ Wrinkles - _____ Deep _____ Fine
○ Pimples/Breakouts - _____ Frequently _____ Sometimes
○ Other concerns: _____

OFFICE NOTES:

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Staff Signature: _____ Date: _____