Skin Evaluation

Name:_____ Age:_____ Date: _____

Have you ever seen a dermatologist for your skin? Y N

Have you previously had:

Chemical Peel? Y N

Type of Peel_____ Date_____

Laser Resurfacing? Y N

Type/Depth (if known) _____ Date _____

Facial Surgery? Y N

Procedure _____ Date _____

Are you pregnant or lactating? Y N

Are you taking Accutane? Y N

Have you ever taken Accutane? Y N

What topical medications do you use or have you used? Retin A ☐ Glycolic Acid ☐

Other: _____

What oral medications do you use or have you used? Tranquilizer ☐ Antibiotics ☐

Hormone/Birth Control ☐ Diuretics ☐

HYPERSENSITIVITY AND FRAGILITY:

Have you ever had a skin allergy? Y N

to: Cosmetics ☐ Fabrics ☐ Aspirin ☐ Other: _____

FREE RADICAL EXPOSURE:

Do you smoke? Y N How much? _____

Do you consume alcohol? Y N How much? _____

Do you have a regular diet? Y N How much? _____

Do you exercise? Y N How much? _____

Do you take vitamins? Y N Multi-Vitamin _____ Other _____

HORMONES:

Do you have regular periods? Y N

Are you going through menopause? Y N

During pregnancy did you get hyperpigmentation or masking? Y N

PIGMENTATION (Fitzpatrick Scale)

How do you tan?

(I) I frequently burn ☐ **(II)** I usually burn ☐ **(III)** I sometimes burn ☐

(IV) I rarely burn ☐ **(V)** I never burn (brown) ☐ **(VI)** I never burn (black) ☐

Pigmentation: Even ☐ Uneven ☐ Birthmark ☐ Pregnancy mask ☐

VASCULARITY:

Broken capillaries: Nose area ☐ Cheeks ☐ Chin ☐ Forehead ☐ Entire face ☐

ACNE:

Do you have a history of acne or periodic breakouts? Y N

Pimples ☐ White heads ☐ Blackheads ☐ Enlarged Pores ☐

Acne Scars ☐ Cysts ☐ Flakiness ☐

FACIAL WRINKLES: Deep wrinkles ☐ Crows Feet ☐ Fine lines ☐

SKIN TYPE:

Does your skin ever flake or feel tight and dry?	Frequently ☐	Occasionally ☐	Rarely ☐
Is your skin ever shiny a few hours after cleansing?	Frequently ☐	Occasionally ☐	Rarely ☐
How often do you experience blackheads or blemishes?	Frequently ☐	Occasionally ☐	Rarely ☐
How noticeable are your pores?	Very ☐	T-Zone ☐	Not very ☐

ABILITY TO HEAL:

Does your skin appear fragile or burn easily?	Y	N
Do you form thick or raised scars from a cut or burn?	Y	N
Do you have any health problems?	Y	N

Explain _____

Do you wax or use depilatories on your face?	Y	N
Do you ever get cold sores?	Y	N

SUN HISTORY AND LIFESTYLE:

Do you work inside or outside? _____

Are your hobbies done mostly inside or outside? _____

In the past (including childhood) did you live in the sunbelt?	Y	N
In the past have you neglected to use a sunblock when outdoors?	Y	N

Nationality? (optional) _____

HAVE YOU OR ANY FAMILY MEMBER HAD SKIN CANCER? Y N

Self: Type of skin cancer _____ Anatomical location of skin cancer _____

Family member: _____ Type of skin cancer _____

WHAT SKIN CHARACTERISTICS WOULD YOU LIKE TO IMPROVE ? _____

WHAT SPECIFIC AREAS DO YOU WANT TO TREAT? Face ☐ Neck ☐ Chest ☐ Back ☐

Patient's signature:	Date:
Technician's signature:	Date: