Patient Skin History

Name: _____ Date: _____

DOB: _____ E-mail: _____

Have you seen a doctor for skin treatment before? Y N If yes, who? _____

Have you previously had a chemical peel? Y N Type of peel: _____Date:_____

Laser or photo treatments? Y N Procedure: _____ Date: _____

Procedure: _____ Date: _____

Are you pregnant or lactating? Y N If yes, when is your due date? _____

Are you actively trying to become pregnant? Y N

Have you or are you taking Accutane? Y N

If you have taken Accutane in the past, what date did you stop taking it? _____

Have you or are you using Retin-A? Y N If yes, what concentration? .1 % .05% .025%

If you have used Retin-A in the past, when did you stop using it? _____

What other topical medications do you or have you used? _____

List your skincare routine:_____

_____

_____

What make-up do you use:_____

HYPERSENSITIVITY AND FRAGILITY

Do you have any skin allergies? Y N

To: Cosmetics Fabrics Aspirin Other: _____

HARMFUL FREE RADICAL EXPOSURE

Do you smoke? Y N How much? _____

Do you use a tanning bed? Y N How often? _____

Do you sunbathe outdoors? Y N How often? _____

HORMONES

Do you have regular periods? Y N

Are you going through menopause? Y N

Did you ever experience hyperpigmentation or masking during pregnancy? Y N If yes, where?_____

Pigmentation Even Uneven Birthmark Pregnancy Mask

VASCULARITY
Capillaries: Nose Area Cheek Area Chin Area Forehead

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 Crow's Feet Fine Lines

SKIN TYPE

Does your skin ever flake or feel tight and dry? Frequently Occasionally Rarely

Is you skin shiny a few hours after cleansing? Frequently Occasionally Rarely

Do you experience blackheads or blemishes? Frequently Occasionally Rarely

How noticeable are your pores? Very Somewhat Not Very

SKIN HEALTH/HEALING

Do you get cold sore or fever blister? Y N If yes, where & how often? _____

Does your skin appear fragile or burn easily? Y N
Do you ever form thick or raised scarring from a cut or burn? Y N

Do you have any health problems that affect your ability to heal? Y N If yes, please list: _____

Do you use hot wax or depilatories on your face? Y N If yes, list where & how often: _____

Do you undergo electrolysis for facial hair removal? Y N

SUN HISTORY AND LIFESTYLE

Do you work inside or outside? Inside Outside

Are you hobbies done mostly inside or outside? Inside Outside

In the past, how often did you apply sunblock before going outdoors?

Always Sometimes Never

How often do you currently use a sunblock? (List frequency, SPF and type) _____

Have you or has any member of your family had skin cancer? Y N If yes, where? _____

How do you want to improve or change your skin? _____