Medical Skincare Assessment

Date: _____/_____/_____

First Name: _____Middle: _____Last Name: _____
Address: _____
City: _____ State:_____ Zip_____
Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____
Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Best time to contact me is:_____ ☐ morning ☐ afternoon ☐ evening **at** ☐ Home ☐ Work ☐ Cell.
If you provide permission to the following, we can send you appointment reminders and special events and discounts:
☐ Okay to leave voicemail? ☐ Okay to send Text? ☐ Okay to send email? ☐ Sign me up for Specials?
If age < 18 then Parent's or Guardian's Name:_____
Employer_____ Work Phone (____)_____
Family Doctor: _____. Group Practice: _____ Phone # (____)_____
Emergency contacts: 1. _____ Phone (____)_____
Provide **email** & you can access your health records online securely: _____

How did you hear about us? ☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Instagram ☐ Twitter
☐ Billboard ☐ Radio ☐ TV ☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Other _____

To the Patient: Your results and safety depend upon a full & complete history

FACIAL TRIAD of AGING

1. AGING of SKIN (thinning of skin, solar changes, wrinkling, all worse with smoking, tan booths, and sun exposure)
2. LOSS of FACIAL VOLUME (primarily fat & bone)
3. LAXITY of Soft Tissue: (Primarily influenced by soft tissue volume loss and the effects of gravity)

Patient Concerns / Desires

FACE / NECK: □ Look younger □ Jowling □ Loose Skin □ Skin tone (Solar changes) □ Wrinkles / Lines
□ Textural changes face □ Eye bags □ Eye lids □ Dark circles under eyes □ Thin lips
□ Nasolabial folds □ Sad mouth □ Gummy smile □ Cheekbone Loss □ Sunken temples

Other: _____

Your Expectations: _____

PERSONAL HISTORY Your safety and optimal results depend upon answering fully and accurately.

- What are your expectations?_____
- Yes No Do you wear contact lenses?
- Yes No Have you ever seen a physician or technician specifically for a skin problem or skincare? If yes, when and for what reason?_____
- Yes No Are you currently under any other **Physician's** or **Provider's** care for your skin? If yes, detail reason(s) _____
- Yes No Have you or any family member ever had a skin lesion or skin cancer removed? Explain: _____
- Yes No Do you have any history of keloids or hypertrophic scars? _____
- Yes No Does your skin become darker after an injury, skin treatment eg laser, microneedling, or surgery?)
- Yes No Do you have any history of radiation? Where? Why? When? _____
- Yes No Do you have ANY skin sensitivities? List all skin sensitivities: _____
- Yes No Do you use any topical medications (prescriptive pharmaceuticals)? (Includes Retin-A, Hydroquinone, Accutane, Benzoyl Peroxide, Antibiotics, MetroGel, Efudex, Cortisone, etc.). List ALL topical medications _____
- Yes No Have you ever taken **Accutane (isotretinoin)**? How long and last dose? _____
- Yes No Have you ever had a "COLD SORE"? When was your last cold sore? _____
- Yes No Ever use depilatories or waxes on your face? If yes, when last used?_____

Do you eat a healthy diet?	**Yes**	**No**	List any dietary concerns _____
Do you exercise?	**Yes**	**No**	If yes, how often? _____
Do you take vitamins?	**Yes**	**No**	If yes, what type(s) _____
Do you drink water?	**Yes**	**No**	If yes, how many glasses per day? _____

Patient Initials: _____

Women Only

GYN: # of Pregnancies _____, # of Births _____, # of miscarriages/abortions _____. Age at menopause _____.

__ Painful intercourse Last menstrual period ___/___/_____. __Irregular, __light, __ medium __heavy menstrual period

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 pregnancy mask? **Yes** **No**

Do you have some trouble with urinary incontinence eg cough, sneeze, laugh? Yes No

SKIN PRODUCT HISTORY

Yes No Do you currently use any skincare products as a regular regimen? If yes, list products used _____

_____

Yes No Have you done any exfoliation to your skin in the last 2 weeks? If yes, explain type(s) of exfoliation _____

SKIN PROCEDURE HISTORY

Please indicate if and when you have had any of the following procedures:

Microdermabrasion	**Yes**	**No**	Date of last procedure _____
Chemical Peels	**Yes**	**No**	Type of peel(s)/date(s) _____
LED/Phototherapy	**Yes**	**No**	Type of procedure(s)/date(s) _____
Laser Resurfacing	**Yes**	**No**	Type of procedure(s)/date(s) _____
Radiofrequency	**Yes**	**No**	Type of procedure(s)/date(s) _____
Dermabrasion	**Yes**	**No**	Type of procedure(s)/date(s) _____
Any Facial Surgery	**Yes**	**No**	Type of procedure(s)/date(s) _____
Other Laser/IPL Procedure	**Yes**	**No**	Type of procedure(s)/date(s) _____
Skin Pen / Microneedling	**Yes**	**No**	Date(s) _____

Other Procedures/dates/Comments?_____

_____

OILY SKIN OR ACNE

☐ History of acne or periodic breakouts? Check if applies: ___Now? __Recent? ____Distal_Past?

Blackheads **Whiteheads** **Enlarged pores** **Pustules** **Cysts**

☐ Do you only experience breakout during or around you menstrual cycle?

☐ Do you ALWAYS have a pimple or some type of breakout? **Frequently** **Occasionally** **Very Rarely**

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

SKIN PORES

☐ Do you have large or noticeable skin pores? **YES** **NO**

SENSITIVE AND INTOLERANT OR DRY SKIN

☐ Flaky skin, itchy skin, or feel tight and dry? **Frequently** **Occasionally** **Very Rarely**

☐ Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.?

☐ Diagnosed with **Rosacea**? When: _____

☐ Diagnosed with **Melasma**? When: _____

☐ Do you have topic or contact dermatitis? **YES** **NO**

☐ Do you have difficulty healing from a cut or burn? If yes, explain:_____

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

☐ Do you have facial wrinkles? Circle **Deep wrinkles** **Crows feet** **Fine lines** **Skin Laxity**

☐ Have you been treated with **Botox?** Date(s) of last treatment_____

☐ Have you been treated with **Fillers?** Date(s) of last treatment_____

☐ Do you work inside? ☐ Outside? Occupation: _____

☐ Are your hobbies done mostly outside? Hobbies: _____

☐ In the past (including childhood) did you live in a sun belt? If yes, where? _____

☐ In the past have you neglected to use sunscreen when outdoors?

☐ Do you use or have you ever used tanning beds? When & how often? _____

☐ Do you currently wear a sun protection product? ☐ all day, ☐ every day?

☐ Are you willing to wear a sun protection product? ☐ all day, ☐ every day?

Past Surgical History (please check all that apply & add date of surgery) □ **No Prior Surgery**

__Abdominoplasty (Tummy Tuck)	__Gastric Bypass / Sleeve	__Neck or Lumbar Spine Surgery
__Breast Surgery	__Heart Surgery / Stent	__Lung Surgery
__Cataract or Eye Surgery	__Hernia	__Pacemaker
__Colonoscopy or Gastroscopy	__Hysterectomy or __D & C	__Thyroid Surgery
__C-Section	__Knee or Hip Surgery	__Vein Surgery, R or L
__Face or Neck Surgery	__Liposuction	__Urinary Bladder Surgery

Any Other Surgeries _____

Any prior Transfusions? Y N. Any problems with anesthesia? Y N. Explain _____

Patient Initials: _____

Past Medical History (please **check** all that apply) (please circle **Active** for all that are currently being treated)

__Abnormal Healing`	Active	__Fibromyalgia	Active	__PCOS-Polycystic Ovarian	Active
__Anemia	Active	__Heart Disease	Active	__Bad Scarring/Keloids	Active
__Anorexia	Active	__Hepatitis, any type	Active	__Seizures	Active
__Arthritis	Active	__High Blood Pressure	Active	__Shortness of breath	Active
__Asthma	Active	__HIV	Active	__Sinus problems	Active
__Bladder Infections	Active	__Insomnia	Active	__Sleep Apnea	Active
__Blood Disorder	Active	__Irregular Heart	Active	__Stroke/TIA	Active
__Bronchitis	Active	__Kidney disease	Active	__Thyroid disease	Active
__Chest pain (angina)	Active	__Liver Disease	Active	__TMJ syndrome	Active
__Cold sores	Active	__Malignant Hyperthermia		__Ulcers, stomach	Active
__COPD/Emphysema	Active	__Motion sickness	Active	__Varicose veins	Active
__Depression	Active	__Neuropathy	Active	__Vision Problems	Active
__Diabetes	Active	__Oxygen use	Active	Other_____	

Review of Systems (Please underline or circle all that apply)

- **Constitutional:** Fever, chills, night sweats, weight loss/gain _____lbs.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **GU:** Some urinary stress incontinence (coughing, sneezing, jogging,etc.)
- **Psych:** Depression, Anxiety, Psychosis, Bipolar

Any history of Radiation: No Yes When & Where: _____

Any prior history of any cancer?-Explain: _____

Medications: (List **all** including prescription, over the counter, birth control, diet pills, hormones, natural supplements), with dosages & frequency: _____

_____

Check those below that apply to you

☐ **Any History of 'Panic' or 'Anxiety' attacks?** Last attack? _____

☐ **Any history of Staph or MRSA infections?** Last episode? _____

☐ **Any bleeding problems?** Explain: _____

☐ **Latex Allergy:** Explain: _____

☐ **Xylocaine "caine" or any local anesthetic Allergy?** Explain: _____

List ALL Drug Allergies: _____

Environmental Seasonal Allergies: _____

☐ Are you presently on any **steroids** or medications containing steroids?

☐ Any **Alcohol use:** How much & how long? _____

☐ Any **Tobacco use:** (check) __ Smoke: __ Dip ___ Chew ___ eCig ___ Cigars. ___ Marijuana. If you quit, when? _____

How much & how long? _____

☐ **History of Substance / Drug Abuse or Alcohol Abuse?** Explain: _____

☐ **Internal Defibrillator or Pacemaker?**

___Single ___Employed ___Disabled ___Retired ___Student ___Married ___Divorced ___Widowed ___Homemaker ___Live alone

Family History of Medical Problems? LIST: _____

_____

HOW DO YOU WANT TO IMPROVE YOUR SKIN? _____

_____

1. Yes No Do you understand that the use of alcohol, drug abuse, and especially tobacco, E-cig, and/or marijuana within a month prior and up to 2 months after any surgical procedure will increase your risks of wound complications including skin necrosis, poor healing, infections, and poor results?
2. Yes No Do you understand there is no guarantee for any result or from any complications?

☐ Fitzpatrick SKIN TYPE: _____ Glogau PHOTO AGING TYPE: _____

Recommendations: _____

_____

Patient Signature: _____ **Date:** _____/_____/_____

Provider Signature: _____ **Date:** _____/_____/_____

Patient Initials: _____