

## SKIN EVALUATION

PATIENT'S 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   
Hormones/Birth Control       Diuretics

### HYPERSENSITIVITY AND FRAGILITY:

Have you every 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 ever get hyperpigmentation or masking?      Y      N

### PIGMENTATION (Fitzpatrick Scale):

How do you tan?  
I Burn       II Usually Burn       III Sometimes Burn   
IV Rarely Burn       V Never Burn-"Brown"       VI Never Burn-"Black"   
Pigmentation: Even       Uneven       Birthmark       Pregnancy Mask

### VASCULARITY:

Broken Capillaries:    Nose area     Cheek area     Chin area     Forehead     Entire Face

### ACNE:

Do you have any history of acne or periodic breakout?    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  Very Rarely   
Is your skin ever shiny a few hours after cleansing? Frequently  Occasionally  Very Rarely   
How often do you experience blackheads or blemishes? Frequently  Occasionally  Very 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 scarring from a cut or burn? Y N  
Do you have any health problems? Y N  
Do you wax or use depilatories on your face? Y N  
Do you ever get cold sores? Y N

SUN HISTORY & LIFESTYLE:

Do you work inside or outside?  
Are your hobbies done mostly inside or outside?  
In the past (including childhood) did you live in a sun belt? Y N  
In the past have you neglected to use a sunblock when outdoors? Y N

Nationality? (optional) \_\_\_\_\_

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

Anatomical location: \_\_\_\_\_

HOW DO YOU WANT TO IMPROVE YOUR SKIN? \_\_\_\_\_

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

Patient Signature:	Date:
Technician Signature:	Date: