Aesthetic Skin Care Center Skin Evaluation

Patient Name:						A	ge:	
Have you ever seen a dermatologist for your skin?			YES	NO				
Are you currently pregnant or lactating?			YES	NO				
Have you ever used or been presc	YES	NO	If yes when:					
What topical medications are you of ACNE • RETIN-A • GLYCOLIC		ig or have u •OTHER	sed:					
What oral medications are you curi			en in the na	st·				
VALIUM HORMONES/ BIRT				•OTHER /AN	ITIBIOTICS			
Do you have any muscular disorde								
Hypersensitivity and Fragility Have you ever had a skin allergy?	YES	NO	If you to y	ıhatı				
riave you ever riau a skiir allergy?	ILS	NO	ii yes, to v	// Idl				
Free Radical Exposure								
Do you Smoke?	YES	NO	How much	?				
Do you consume alcohol?	YES	NO	How much	?				
Do you have a regular Diet?	YES	NO		2				
Do you exercise?	YES YES	NO NO	How muchMulti-vita					
Do you take vitamins?	IES	NO	• Mulli-Vila	umm •Anuk	oiotic •Othe	er		
<u>Hormones</u>								
Do you have regular periods?	2	YES	NO					
Are you going through menopause During pregnancy did you ever get		YES	NO	VEC NO	N/A			
During pregnancy did you ever get	. Hyperpigilie	illation of h	iaskiriy	YES NO	N/A			
Pigmentation (Fitzpatrick Scale)								
How do you tan?	•Burn		• Usually E			Sometimes E		
D:	• Rarely Bu	rn	• Never Bu			Never Burn I		
Pigmentation is:	• Even	• Uneve	en	•Birthmark	• 1	Pregnancy M	lask	
Vascularity								
Broken capillaries: •Nose	• Cheeks	•Chin •	Forehead	•Entire Fac	ce			
Anna								
Acne Do you have a history of acne or p	eriodic brea	voute2	VEC	NO				
• Pimples • White-heads • Bla					cne Scars •	Cysts		
·		3				,		
Facial Wrinkles		. Fine Line						
• Deep Wrinkle • Crows fee	eτ	• Fine Line	S					
Skin Type								
Does your skin ever flake or feel lig			 Frequent 		Occasionally		 Rarely 	
Is your skin shiny a few hours after			 Frequent 		 Occasionally 	•	 Rarely 	
Do you experience blackheads or f	acial blemish	nes?	• Frequent		• Occasionally	,	• Rarely	
How noticeable are your pores?				iceable	• Just in T-zo	ne	• Not Noticeable	
Ability To Heal								
Does your skin appear fragile or b	urn easily?		YES	NO				
Do you form thick or raised scarring from cuts or burns? YES NC								
Do you have any existing health problems?				NO				
Do you wax or use depilatories on your face?				NO				
Do you ever get cold sores?			YES	NO				
Sun History and Lifestyle								
What percentage of time so you sp	end in the s	un?		Summer	•Winter •\	Year-round		
In the past (incl. childhood) did yo			r sunbathe?	YES	NO			
In the past have you neglected to				YES	NO			
Have you ar any mamber of your f	omilu ovor b	d akin cana	.or2					
Have you or any member of your for YES NO If yes, whe	re on the bo		<u>ærr</u>					
TES ITO IT yes, who	re on the bo	чу. <u></u>						
How would you like to improve you	<u>ır skin?</u>							
What specific areas would you like	to treat?							
• Face • Neck • Chest	•Back	• Hand	• Forea	arms	•Lower Legs	•Other_		
•					J			
Signature					Da	ate	1 1	