Skin Evaluation Form

Patient _____ Race_____ Age_____

Please fill in the following description of your facial complexion. This information is necessary for us to design a skin program for you.

Conditions	**(Circle yes or no)**	**Office Notes**
Y or N	Sun Damage	_____
Y or N	Brown Spots (or splotchy, uneven skin color)	_____
Y or N	Upper Lip Lines – Deep ____ Fine____	_____
Y or N	Freckles	_____
Y or N	Wrinkles - Deep ____ Fine____	_____
Y or N	Hard bumps under skin	_____
Y or N	Clogged pores	_____
Y or N	Excessive oiliness	_____
Y or N	Acne	_____
Y or N	Pimples – Often ____ Sometimes____	_____
Y or N	Blackheads ____ Whiteheads ____	_____
Y or N	Dry Patches	_____
Y or N	Visible Exposed Blood Vessels	_____

What type of skin do you have? ____Normal to Dry ____Normal to Oily Do you tan? ____Easily ____Burn

Any chronic skin or medical disorders? ____Psoriasis ____Dermatitis ____Fever Blisters ____Hepatitis

List medications/supplements you are using: _____

Do they make you photo-sensitive? Y or N

What cosmetic ingredients/medications are you allergic: _____

Are you using: Retin A Y or N What strength? _____ How Long? _____

Accutane Y or N Zovirax Y or N Taking Antibiotic oral/topical Y or N

Tetracycline Y or N Any facial scarring? Y or N Facial Region: _____

Have you had or planning to have any facial surgery? Y or N

Any prior cosmetic peels? ____Salon ____TCA ____Phenol ____Other Date _____

Pregnant? Y or N Breastfeeding? Y or N Oral Contraceptives? Y or N Hormone Imbalance? Y or N

Date of your last period? _____ Excessive Hair face/breasts? Y or N

Facial Hair Removal? ____Wax ____Other Date:_____

Please check the products you are currently using and list the brand names:

___Cleanser _____ ____Soap _____ ____Toner _____

____Moisturizer _____ ____Night Cream _____ ____Other _____

____Eye Cream _____ ____Astringent _____ ____Mask _____

____Scrub _____ ____Sunscreen_____