Skin Evaluation Form

Name______________________________DOB_____________Age_______Date________

Are you pregnant or lactating? Yes____ No____Trying to get pregnant? ___________
Do you wear contacts? Yes____ No_____ (remove contacts if eyes are sensitive)
Do you have permanent makeup? Yes____ No____ If so, what areas?_____________
Are you currently sun or wind burned? Yes____ No____ If so, how recently?_______
Do you go to tanning booths? Yes____ No____ If so, how recently?______________
Do you use Biore Strips? Yes____ No ____ If so, how recently?__________________
Are you currently using depilatories? Yes____ No____ If so, How recently?________
Are you waxing any areas on your face? Yes____ No____ How recently?__________
Are you currently seeing a Dermatologist for your skin? Yes____ No___ When?_____
Are you currently using Retin A / Differin / Renova /Avage? Yes___ No___
If so, what strength_____________
Are you currently using Tazorac? Yes____ No____ How Recently?________________
Are you currently using ANY topical benzoyl peroxide preparations? Yes____ No___
Benzaclin____ Benzamyacin____ OTC BPO____ ProActiv____ Other____________
Discontinue using Retin A, Renova, Differin, Tazorac, Avage & Benzoyl Peroxide approx. 3 days prior to and 3 days after any skin rejuvenating treatment unless instructed otherwise.
Are you currently taking any oral medications? If so, please list: _________________
____
Do you have any health problems or hormonal disorders?________________________
Do you have regular periods? Yes___ No___ Going through menopause? Yes__ No__

Have you had a chemical peel or any type of procedure with a medical device?
Yes____ No____ Within the past 14 days? Yes____ No_____ Specify?_____________
Do you have regular collagen injections? Yes____ No____ How recently?__________
Do you have regular Restylane injections? Yes____ No____ How recently?_________
Do you have regular Botox injections? Yes____ No____ How recently?____________

What type of work do you do?____
Do you participate in aerobic activity? Yes___ No___ Do you smoke Yes____ No____

Have you had recent facial surgery? Yes___ No___ Describe:_____________________
Have you EVER had a cold sore / fever blister? Yes____ No____ How recently_____

Are you allergic or sensitive to (**circle** all that apply) Milk Apples Citrus Grapes Aloe Vera Aspirin Perfumes Latex Hydroquinone Mushrooms
List any other allergies you have:____

Continued…..

Describe your skin <u>in your opinion</u> **(circle all that apply):**
Oily Acne Prone Thick Thin Saggy Firm Normal

Dry Blackheads Breakouts Acne Scarred Large Pores Small Pores Rosacea
Eczema Freckled Sun-Damaged Uneven-Blotchy Mature Wrinkled Fine Lines
Patchy Dryness Melasma Dehydrated Asphyxiated(congested) Telangiectasias
(small broken capillaries) Rough Texture
Hypopigmented (loss of pigment)

OTHER:____

____

What are the cosmetic improvements you would like to see in your skin?

____

What is your EYE Color: Blue____ Green____ Hazel____ Gray____ Light Brown____ Medium Brown____ Dark Brown____

Natural HAIR Color: Blonde____ Red____ Light Brown____ Medium Brown____ Dark Brown____ Dark Brown____ Black____ Gray/Silver____ White____

What is your current skin care regime?
(P lease tell me what you do and what products you use)

A.M.

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4.
5.

P.M.

1.
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