First Name ________________________ Last Name ________________________

Skin Evaluation Information
Clinical Skin Evaluation & Analysis

Please list the prescriptions you are currently taking: ____

____

Current nutritional and vitamin supplements: ____

Please list any allergies (Drugs, food, seasonal, etc): ____

Have you had any facial surgery or laser resurfacing? When? What kind? ______________________________

____

Please circle if you have had any of the following conditions:

Acne/ Rosacea/ Thyroid Dysfunction/ Hypertension/ Cancer/ Keloids/ Immunological problems/ Diabetes/ HIV/ Herpes, cold sores, warts, recurrent viral infections/ Eczema/ Photosensitivity/ Hyperpigmented areas from old injuries/ Epilepsy/ Spinal Injury/ Hysterectomy

Have you had any other significant illnesses?____

Do you currently or have you ever smoked? Yes☐ No☐ Explain: ______________________________

Do you currently or have you ever visited tanning beds? Yes☐ No☐ Explain: ______________________

Do you wear contact lenses? If so, please remove before facial or eyelash treatment. Yes☐ No☐

Do you have any metal implants, pacemaker or body piercings? Yes☐ No☐

Are you pregnant, trying to become pregnant or recently pregnant (1 year)? Yes☐ No☐

Do you exercise regularly? Explain ____

Do you follow a restricted diet? Explain ____

How many glasses of caffeine do you consume daily? ____

How many glasses of water do you consume daily? ____

Are you currently or have you ever used Retin A/ Renova/ Differin/ Adapalene or other topical prescriptions?

Yes☐ No☐ Explain____

Are you currently or have you ever used Accutane? Yes☐ No☐ Explain ______________________________

Have you ever had any professional chemical peels or microdermabrasion? Yes☐ No☐

If yes, when and what kind?____

Do you currently have professional facials? Yes☐ No☐

Do you currently have sunburn, windburn, or a red face? Yes☐ No☐

Do you currently get facial waxing/ threading/ electrolysis or use depilatories? Yes☐ No☐

Which area and when was the last time?____

Do you suffer from occasional breakouts? Yes☐ No☐

Does your skin get irritated easily? Yes☐ No☐

Are you using Glycolic/ AHA home care products? Yes☐ No☐

If so, which ones? ____

Have you ever used any products that caused a bad reaction? Yes☐ No☐

Please describe:____

Please describe you daily home care regimen. Please be specific. *(i.e. brand names, type of products, etc.)*

Morning:____

Evening:____

Weekly:____

Self Skin Evaluation

I would describe my skin as: ☐ Dry ☐ Normal ☐Oily ☐ Mixed

The natural color of my hair and eyes are: ____

Sunburn History: ☐ Always ☐ Usually Burns ☐ Sometimes Burns ☐ Rarely Burns ☐ Never Burns

Suntan History: ☐Never Tans ☐ Tans with Difficulty ☐ Tans Average ☐Tans Well ☐ Tans Easily

Sun Exposure Index Growing Up:

☐ Minimum- Rarely or never exposed to the sun

☐ Mild- Exposure on the average of 2 weeks per summer

☐ Moderate- Exposure 4-6 weeks every summer

☐ Heavy- Nearly continuous exposure late spring, summer, early fall

☐ Extreme- Exposure all year round, tropical residence, high altitude or extensive tanning bed use

Have you ever had severe sunburn (Blistering, Swelling or requiring medical attention)? ☐No ☐Yes

If so, when and what areas? ____

How often do you use sun protection? ☐Never ☐Rarely ☐Frequently ☐Always

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

____

____