SKIN HEALTH ASSESSMENT Date:

CONFIDENTIAL

Client Name_____
Last First Middle Initial

Address_____
Apt/Ste. Street City State Zip

DOB____/____/_____Phone_____Email_____

Emergency Contact:

Name_____Relationship_____Phone_____

Woul you like to receive our newsletter? YES_____NO_____

Reffered by:

[_]Internet___[_]Ad_____[_]Social Media Site-_____[_]Mailer_____

[_]Friend or Family (Name)_____Other_____

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ESTHETICS

SKIN HEALTH ASSESSMENT

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Reason for consultation_____

Special area of concern_____

Expectations and History

Conditions you would like to improve:

[ ] Acne [ ] Hyperpigmentation [ ] Age Spots [ ] Enlarge pores

[ ] Acne Scars [ ] Fine lines/wrinkles [ ] Other_____

How would you describe your skin:

[ ] Normal [ ] Dry [ ] Oily [ ] Combination [ ] Sensitive [ ] Sun Damaged

Do you experience:

[ ] Tightness [ ] Flakiness [ ] Erythema [ ] Excessive oil production during the day

With sun exposure does you skin:

[ ]Always burns, never tans

[ ] Burns easily, tans slightly

[ ] Burns moderately, tans gradually

[ ] Seldom burns, always tans

[ ] Rarely burns, deep tan

[ ] Never burns, always tan darkly

Do you use sunscreen regularly: [ ] Yes [ ] No

Do you blush easily: [ ] Yes [ ] No

If yes, what are your contributing Factors: [ ] Emotions [ ] Temperature Changes [ ] Food

[ ] other:_____

Present regimen and current skin care products:

Please check ALL that apply, both past and present:

[ ] Microdermabrasion	[ ] Laser Resurfacing	[ ] Chemical Peels
[ ] Facial Surgery	[ ] Botox	[ ] Pigmentation disorder
[ ] Dermal Fillers	[ ] Photosensitivity	[ ] Chronic skin condition
[ ] Keloids	[ ] Tetracycline use	[ ] Herpes simplex/cold sores
[ ] Accutane	[ ] Electrolysis	[ ] Use of tanning bed

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Lifestyle and Diet

Stress Level [ ] High [ ] Medium [ ] High

Regular Exercise [ ] Yes [ ] No

Daily Hours of Rest_____

Food Intolerances_____

Daily Caffeine Intake_____

Daily Water Intake_____

Smoking Status: [ ] Current Smoker [ ] Former Smoker [ ] Never a Smoker

Alcoholic Beverages Per Week:_____

Medication and Supplements:

_____

_____

_____

List any special skin care products you use:

_____

_____

_____

For Men:

Do you shave with an electrical Shaver: [ ] No [ ] Yes

Do you have ingrown hairs: [ ] No [ ] Yes

Do you experience Skin breakouts: [ ] No [ ] Yes

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MEDICAL HISTORY

How would you rate your overall health: [ ] Excellent [ ] Good [ ] Poor

Are you currently treatment for any skin condition: [ ] Yes [ ] No

Does your skin heal: [ ] Fast [ ] Scars [ ] Pigment

Does skin bruise easily: [ ] No [ ] Yes

Allergies to Medications: [ ] No [ ] Yes_____

Have you ever used:

[ ] Accutane [ ] Retin-A [ ] Renova

[ ] Differin [ ] Tazarac [ ] Topical Antibiotics

[ ] Hydroquinone [ ] Alpha Hydroxyl Acids If yes how long:_____

Any History of:

[ ] Blood Pressure [ ] Diabetes [ ] HIV/AIDS [ ] Hepatitis

[ ] Lupus [ ] Thyroid [ ] Skin Cancer [ ] Cholesterol

[ ] Menopausal [ ] Pace Maker [ ] Eczema [ ] Claustrophobic

[ ] MRSA [ ] Phlebitis [ ] Bursities [ ] HayFever/ Allergies

[ ] Blood Clots [ ] Asthma [ ] Headaches [ ] Sclerodema

[ ] Chest pain [ ] Cancer [ ] Metal Implants [ ] Heart Diasease/Condition

For Women:

Oral Contraceptives: [ ] No [ ] Yes

Are you pregnant: [ ] No [ ] Yes

Taking Hormone replacement: [ ] No [ ] Yes

Experience hormone imbalences: [ ] No [ ] Yes

In our treatment program it may be necessary to recommend alterations or additions to your home care regimen. Would that be okay with you? [ ] No [ ] Yes