SKIN SPECIALISTS
OF THE CAPITAL REGION
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COSMETIC AND ESTHETIC SERVICES SELF-ASSESSMENT

Patient Name: First _____ Last _____ DOB: _____
Address: _____
Telephone: Home ( )_____ Cell ( ) _____ Work ( ) _____
Email address: _____

Please complete the following questions regarding your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate strategies for you and your follow up services.

MEDICAL HISTORY

1a. Are you currently taking any of the following types of oral and topical medications:

___Aspirin
___Anti-coagulants
___Appetite depressant
___Cortisone
___Herbal preparations (i.e., St. John's Wort, etc.)
___Hormones/oral contraceptives
___Insulin
___Retinoid creams
___Sedatives/tranquilizers
___Vitamins

1b. Specify all oral and topical medications you are taking: _____
_____

2. Of the medications taken above, do any make you more sensitive to the sun or cause thinning of the blood? ___Yes ___No

3. Have you ever had any of the following:

___Bleeding disorder
___Easily-bruised skin
___Keloid scarring
___Dark spots after pregnancy
___Heart disease
___Septicemia
___Diabetes
___Herpes sores

4. Allergies: _____
5. Allergies to medications: ___Yes ___No If yes, specify _____
6. Daily consumption of alcohol: _____
7. Do you smoke: ___Yes ___No
8. Do you wear contact lenses: ___Yes ___No
9. Are you pregnant, nursing or planning a pregnancy soon: ___Yes ___No

Sun Exposure Habits

1. Last exposure to the sun (including tanning booths): _____
2. Do you go to a tanning booth: ___Yes ___No If Yes, specify frequency_____
3. Do you use chemical self-tanning products? ___Yes ___No
4. Are you planning a holiday in the sun: ___Yes ___No If Yes, when? _____

Skin Characteristics

1. Fitzpatrick Skin Type Scale:

   Please circle your skin type, based upon your response to summer sun.

___	Type I	Light, pale white skin. Always burns, never tans
___	Type II	Light, fair skin. Always burns, tans with difficulty
___	Type III	Medium, white to olive skin. Sometimes mild burn, gradually tans to olive
___	Type IV	Olive, moderate brown skin. Rarely burns, tans with ease to moderate brown
___	Type V	Brown, dark brown skin. Very rarely burns, tans very easily
___	Type VI	Black, very dark brown to black skin. Never burns, tans very easily, deeply pigmented

2. Fitzpatrick Wrinkle Class Scale: Please circle the appropriate class.

___	Class I	Fine wrinkles
___	Class II	Fine to moderate depth wrinkles, moderate number of lines, minimal skin folds
___	Class III	Fine to deep wrinkles, numerous lines, and prominent skin folds

Consult Information

1. What is the main reason(s) you have come for this assessment?

___Acne
___Dark circles/puffiness in eyes
___Eye lashes ~ sparse/light
___Eyebrow and/or eyelid drooping
___Facial redness
___Facial wrinkles/folds
___Facial veins
___Hand aging
___Leg veins
___Lines around nose/ mouth
___Lips ~ vertical lines
___Lips ~ reduced definition/thinning
___Neck wrinkles/folds
___Skin texture and tone
___Skin pigmentation/age spots
___Scars (acne or surgical)
___Uneven skin tone/ discoloration
___Unwanted hair
___If other, please specify:
_____
_____
_____
_____

2. Please specify how long this has been an issue for you and whether it has become more pronounced over time? _____

_____

_____

3. Please detail the aesthetic treatments and procedures, if any, you have had in the past.

_____

_____

_____

4. If you previously had any aesthetic treatments or procedures, were you pleased with the outcome?
___Yes ___No If no, in what way were you dissatisfied? _____

_____

_____

_____

5. Do you have any concerns about aesthetic treatments and procedures? ___Yes ___No
If yes, please identify your concerns? _____

_____

_____

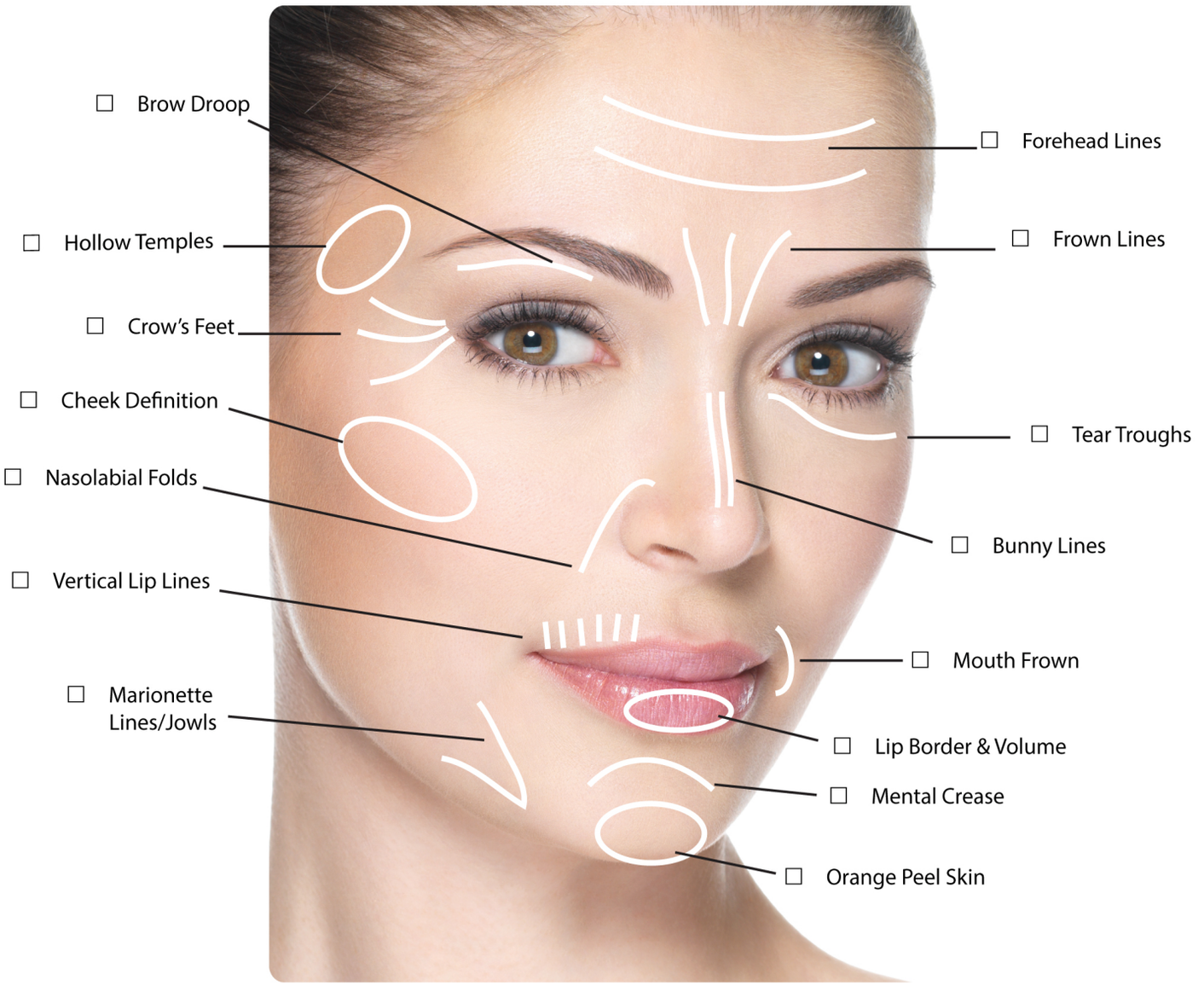
_____

6. Would you prefer that products used for your aesthetic treatment and services do not contain animal-derived ingredients? ___Yes ___No ___Not sure, I would like to discuss

7. Please identify the following aesthetic treatments/procedures/products that interest you or would like to know more about. Please check all that apply.

___Acne treatment
___Age Spot Correction
___Chemical/Enzyme Peel
___Dermal Filler
___Facials
___Facial Vein Treatment
___Intense Pulse Light (IPL)/ Photo facial
___Hand "Lift"
___Laser Treatment
___Laser hair removal
___Latisse
___Leg Vein Treatment
___Liquid "Facelift"
___Microdermabrasion
___Neck care
___Skin Care Planning/ Treatment
___Skin Care Products
___Sun Protection Products
___VISIA Complexion Analysis
___Wrinkle Smoothing (i.e., Botox or other neurotoxin)
___If other, please specify:
_____
_____

8. Please identify those areas of the face that bother or trouble you. In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



Patient Signature: _____ Date: _____