

SKIN & MEDICAL HISTORY FORM

Name: _____ Date of Birth / / Date: _____
M D Y

Referring Physician _____

Reason for today's visit _____

SKIN CONCERNS: Describe your skin type (check one): Oily Normal Dry Sensitive Combination

Concerns (check all that apply)	Severity	How long has problem persisted?
<input type="checkbox"/> Wrinkles	mild moderate severe	_____
<input type="checkbox"/> Sun spots (melasma/hyperpigmentation)	mild moderate severe	_____
<input type="checkbox"/> Large pores	mild moderate severe	_____
<input type="checkbox"/> Skin laxity	mild moderate severe	_____
<input type="checkbox"/> Skin flushing (rosacea)	mild moderate severe	_____
<input type="checkbox"/> Enlarged blood vessels (telangiectasias)	mild moderate severe	_____
<input type="checkbox"/> Hair growth/excessive hair	mild moderate severe	_____
<input type="checkbox"/> Surgical Scars	mild moderate severe	_____
<input type="checkbox"/> Acne Scars	mild moderate severe	_____
<input type="checkbox"/> Acne	mild moderate severe	_____
<input type="checkbox"/> Eczema	mild moderate severe	_____
<input type="checkbox"/> Psoriasis	mild moderate severe	_____
<input type="checkbox"/> Keratosis polaris (red rash)	mild moderate severe	_____

For which of these concerns have you been treated? _____

Please check aesthetic treatments you have had:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Laser Vein Treatment | <input type="checkbox"/> Intense Pulsed Light (IPL) | <input type="checkbox"/> Laser Resurfacing | <input type="checkbox"/> Chemical Peel |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Fillers | <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Laser Acne Treatment |
| <input type="checkbox"/> Light Emitting Diode (LED) | <input type="checkbox"/> Laser Skin Rejuvenation | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Fractional laser treatment | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Body Contouring | <input type="checkbox"/> Facelift |
| <input type="checkbox"/> Other _____ | | | |

Date of last treatment _____ **Which treatment?** _____

SUN EXPOSURE: How much sun exposure do you get? None Some Frequent

Last time you were in the sun? _____

Do you use tanning booths? Yes No Last use _____

Do you use self-tanners? Yes No Last use _____

Do you use sunscreen? Yes No If yes, how often? _____ SPF _____

SKIN CARE: What skincare products do you use daily? None Cleanser Toner Exfoliant Moisturizer

Eye Cream Retin-A Bleaching/Hydroquinone Skin Repair Other _____

Which products would you like to add to your skin care regimen?

LIFESTYLE ASSESSMENT

Are you pregnant, nursing or planning a pregnancy soon? Yes No If yes, please explain _____

Do you wear contact lenses? Yes No

Have you ever smoked? Yes No If yes, when did you start and for how long? _____

Water Consumption / day _____

Caffeine Consumption / day _____

Alcohol Consumption / day _____

List all vitamins & herbal supplements you currently take & frequency of use.

HAIR REMOVAL: Which hair removal methods are you currently using:

None Waxing Depilatories Shaving Laser/IPL Electrolysis Threading

Date of last treatment: _____ Are you satisfied with the results? Yes No

What area(s) do you wish to treat? _____

MEDICAL HISTORY: Do you have a history of:

- Cold sores/fever blisters HIV infection Skin cancer/suspicious moles Deep vein thrombosis
- Migraine headaches Hepatitis Clotting disorder Heart disease
- Epileptic seizures Easy bruising Hypertension Keloid scarring
- Diabetes Skin injury Other _____

MEDICATIONS & SENSITIVITIES: Check all medications that you currently take:

- Aspirin Hormones/contraceptives Thyroid medication
- Anti-coagulants (blood thinners) Insulin Appetite depressant (diet pills)
- Cortisone/steroids Sedatives Tranquilizers
- Acutane Other _____

Do you have an allergy to lidocaine? Yes No

Do you have an allergy to latex products? Yes No

Please list other allergies and sensitivities:

Please list any medical conditions for which you are being treated:

Please list any surgeries and hospitalizations and when they occurred:

SKIN TYPING: Calculate your skin type by completing the charts below.

Genetic Disposition

Score	0	1	2	3	4
What is your eye color?	Light blue, gray, green	Blue, gray or green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair	Sandy red	Blonde	Chestnut, dark blonde	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

Total score for Genetic Disposition _____

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never burns
To what degree to you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure	Never	Seldom	Sometimes	Often	Always
How does your face react to sun?	Very sensitive	Sensitive	Normal	Very resistant	No reaction

Total score for Reaction to Sun Exposure _____

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total score for Tanning Habits _____

Total the scores for all three sections to determine your Skin Type Score: _____

Skin Type Score	Fitzpatrick Skin Type
0 – 7	I
8 – 16	II
17 – 25	III
25 – 30	IV
Over 30	V - VI

Patient or Responsible Party Signature _____ **Date** _____