Skin Evaluation Form

Doctors of Internal Medicine

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:_____

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Describe your skin in your opinion **(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?

A.M.

1. _____
2. _____
3. _____
4. _____
5. _____

P.M.

1. _____
2. _____
3. _____
4. _____
5. _____

DOCTORS USE ONLY

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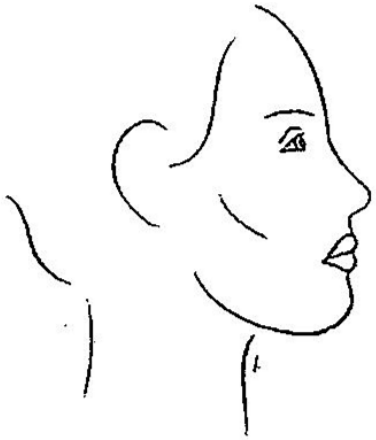

- ☐ Sun Damage
- ☐ Brown Spots
- ☐ Upper Lip Lines:

  Deep Fine
- ☐ Freckles
- ☐ Wrinkles

  Deep Fine
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Hard Bumps Under Skin
- ☐ Milia:

  Red White
- ☐ Clogged Pores
- ☐ Excessive Oiliness
- ☐ Acne
- ☐ Pimples:

  Often Sometimes
- ☐ Dry Patches
- ☐ Visible Broken Blood Vessels

Type of Skin:

- ☐ Dry
- ☐ Normal / Combination
- ☐ Oily

Doctor's Notes