SANTA ANA SKIN CARE CLINIC

Skin Evaluation

Client Name____Age________DOB________________
Address____Zip Code______________
Home Phone________________________________Work_______________Other___________________
Last Visit with a dermatologist__________________________ Why____________________________

Have you previously had:
Chemical Peel __**Y** ___**N** Type of Peel________________________Date______________
Resurfacing/Dermabrasion/Microdermabrasion? ___**Y** ___**N** If Yes, list________________________
Facial Surgery? ___**Y** ___**N** Procedure:____________________________________Date____________
Have you done any aggressive exfoliation in the last two weeks? ___**Y** ___**N**
If yes, explain____

Are you taking Accutane? ___**Y** ___ If yes, how often/dosage________________________
Have you taken Accutane in the past? ___**Y** ___**N** If yes, when?_____________________________

Check the topical medications you use or have used in the past:
☐ Retin A ☐ Hydroquinone ☐ Hydrocortisone ☐ Topical Antibiotics
☐ Other______________On what area of the body?_____________________________________

Please list any oral medications you currently take, including all hormones, birth control pills, antidepressants, tranquilizers and diuretics____
____

Please list nutritional supplements you are currently taking?_________________________________
____

What skin care products do you use frequently?____
____

Hypersensitivity and Skin Fragility
Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives, etc)?
___Y ___N If yes, explain____
____
Do you have any known allergies to anything ___Y ___N If yes, please list (including medications, aspirin, and foods)____
Do you flush easily or appear reddened when you eat spicy food, drink alcohol, go in the sun, etc.? ___Y ___N

Free Radical Exposure
Do you smoke? ___Y ___N How much___________________________
Do you consume alcohol? ___Y ___N How much___________________________
Do you have a healthy diet? ___Y ___N
Do you exercise? ___Y ___N If yes, how often?______________________

Female
Do you have regular periods ___Y ___N
Are you going through menopause? ___Y ___N
Are you pregnant? ___Y ___N
Are you lactating? ___Y ___N
Have you ever been pregnant? ___Y ___N
If yes, did you experience hyper-pigmentation or a "pregnancy mask"? ___Y ___N

Pigmentation: ☐ Even ☐ Uneven ☐ Birthmark

How do you tan?

(over)

☐ Burn ☐ Usually Burn ☐ Sometimes Burn ☐ Rarely Burn ☐ Never "Brown"
☐ Never "Black"

Broken Capillaries:
☐ Nose ☐ Cheeks ☐ Chin ☐ Forehead ☐ Entire Face

Acne:
☐ Periodic Breakouts ☐ Pimples ☐ White heads ☐ Black heads
☐ Cysts ☐ Enlarged pores ☐ Acne scars ☐ Flakiness
☐ Breakout only dring menstrual cycle ☐ History of cold sores
☐ Always a pimple or some type of breakout

Facial Wrinkles:
☐ Deep wrinkles ☐ Crows feet ☐ Fine lines
Have you been treated with Botox? ___Y ___N Collagen? ___Y ___N
If yes, date of last treatment ____________________

Skin Type: (Please check one)	**Frequently**	**Occasionally**	**Rarely**
Does your skin appear fragile or burn easily?	☐	☐	☐
Do you have problems healing from a cut or burn?	☐	☐	☐
Do you have health problems?	☐	☐	☐
Do you ever use depilatories/waxes on your face?	☐	☐	☐
Have you ever had a cold sore?	☐	☐	☐
How noticeable are your pores?	☐ Very	☐ T-Zone	☐ Not very

UV Exposure
Do you work inside? ___Y ___N Occupation:____________________
Are your hobbies done mostly outside? ___Y ___N Hobbies:____________________
Have you ever lived in the sun belt? ___Y ___N Where?____________________
Do you use tanning beds? ___Y ___N If yes, when?____________________
Do you currently wear sun protection? ___Y ___N Every day? ___Y ___N
Are you willing to wear sun protection everyday? ___Y ___N

Have you or any member of your family had skin cancer? ___Y ___N
Where was the cancer located?____________________

Are you currently seeing a physician for any reason? ___Y ___N

If yes, explain____________________

What specific areas would you like to treat?
☐ Face ☐ Neck ☐ Chest ☐ Arms ☐ Hands ☐ Back ☐ Other
How do you want to improve your skin?

____

Do you wear contact lenses? ___Y ___N

Client Signature:	**Date**
Technician Signature:	**Date**
M.D. Signature:	**Date**

Recommendations:____________________