

# MEDICAL SKINCARE ASSESSMENT

(SAMPLE)

PATIENT'S NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Do you wear contact lenses? Yes No

## **PERSONAL HISTORY**

Are you currently seeing a physician for any reason? Yes No

If yes, explain reason \_\_\_\_\_

Have you ever seen a physician or technician specifically for a skin problem or skincare? Yes No

If yes, when and for what reason? \_\_\_\_\_

Are you currently under any other physician's or technician's care for your skin? Yes No

If yes, detail reason(s) \_\_\_\_\_

Have you or any family member ever had a skin lesion removed by a physician? Yes No

If yes, who had lesion removed? \_\_\_\_\_ Anatomical location of lesion? \_\_\_\_\_

Do you have any health problems? Yes No If yes, list \_\_\_\_\_

Do you have any allergies or skin sensitivities? Yes No

If yes, list all allergies/skin sensitivities \_\_\_\_\_

Do you currently take any oral medications (prescriptive pharmaceuticals)? Yes No

(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.)

If yes, list all oral medications \_\_\_\_\_

Do you use any topical medications (prescriptive pharmaceuticals)?

(includes Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

If yes, list all topical medications \_\_\_\_\_

Have you ever taken Accutane®? Yes No

I currently take Accutane: Dosage prescribed \_\_\_\_\_ Frequency taken \_\_\_\_\_

I took Accutane in the past:: Date discontinued \_\_\_\_\_ Dosage/frequency used \_\_\_\_\_

Have you ever had a "COLD SORE"? Yes No If yes, when was your last cold sore? \_\_\_\_\_

Do you ever use depilatories or waxes on your face? Yes No If yes, when last used? \_\_\_\_\_

Do you smoke? Yes No If yes, how much/often? \_\_\_\_\_

Do you consume alcohol? Yes No If yes, frequency/amount \_\_\_\_\_

Do you have a healthy diet? Yes No List any dietary concerns \_\_\_\_\_

Do you exercise? Yes No If yes, how often? \_\_\_\_\_ Type(s) \_\_\_\_\_

Do you take vitamins? Yes No If yes, what type(s)? \_\_\_\_\_

Do you drink water? Yes No If yes, how many glasses per day? \_\_\_\_\_

*For women only:*

Do you have regular periods? Yes No

Are you going through menopause? Yes No

Are you trying to become pregnant? Yes No Are you in a fertility program? Yes No

Are you pregnant or lactating? Yes No Have you ever been pregnant? Yes No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Yes No

## **SKIN PRODUCT HISTORY**

Do you currently use skincare products as a daily regimen? Yes No

If yes, list products used \_\_\_\_\_

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes No

If yes, explain type(s) of exfoliation \_\_\_\_\_

**SKIN PROCEDURE HISTORY**

Have you previously had any of these skin procedures (treatments)? Yes No If no, skip this section.
Microdermabrasion Yes No Date of last procedure
Chemical Peel(s) Yes No Type of procedure(s)/date
Phototherapy Yes No Type of procedure(s)/date
Laser Resurfacing Yes No Type of procedure(s)/date
Radiofrequency Yes No Type of procedure(s)/date
Dermabrasion Yes No Type of procedure(s)/date
Facial Surgery Yes No Type of surgery(s)/date
Other procedures/date?
Additional comments about above procedure(s)

**OILY SKIN OR ACNE**

Any acne breakout? Blackheads Whiteheads Enlarged Pores Pustules Large pores Cysts
Do you have any history of acne or periodic breakout? Yes No If yes: Now? In past?
Do you only experience breakout during or around your menstrual cycle? Yes No
Do you always have a pimple or some type of breakout? Yes No
Does your skin ever flake or feel tight and dry? Frequently? Occasionally? Very rarely?
Is your skin ever shiny (oily) a few hours after cleansing? Frequently? Occasionally? Very rarely?
How noticeable are your pores? Very? T-zone only? Not very noticeable?

**SENSITIVE AND INTOLERANT OR DRY SKIN**

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.? Yes No
Does your skin ever get flaky or itch? Yes No If yes, is it seasonal or all the time?
Have you ever been diagnosed with Rosacea? Yes No If yes, when was the diagnosis made?
Do you have difficulty healing from a cut or burn? Yes No If yes, explain
Have you ever had keloid scarring? If yes, explain

**PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN**

Do you have facial wrinkles? Deep wrinkles Crows feet Fine lines Skin Laxity
Have you been treated with: Botox? Fillers? If yes, date of last treatment
Do you work inside? Yes No Occupation
Are your hobbies done mostly outside? Yes No Hobbies
In the past (including childhood) did you live in a sun belt? Yes No If yes, where?
In the past have you neglected to use a sunscreen when outdoors? Yes No
Do you ever use tanning beds? Yes No If yes, when?
Do you currently wear a sun protection product all day, everyday? Yes No
Are you willing to wear a sun protection product all day, everyday? Yes No

**Fitzpatrick Scale** (how your skin reacts to sun exposure). How do you tan?

I Burn II Usually Burn III Sometimes Burn
IV Rarely Burn V Never Burn-"Brown" VI Never Burn-"Black"
Is your skin pigmentation (skin discoloration): Even Uneven Birthmark(s) Pregnancy Mask
What is your Ethnicity and Race (heritage)?

**HOW DO YOU WANT TO IMPROVE YOUR SKIN?**

1.
2.

**WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?**

Face Neck Chest Back Other

Table with 2 columns: Signature (Patient, Technician, M.D.) and Date.