PATIENT'S NAME:_______________________________ AGE:_______DATE: ___/___/___

EMAIL ADDRESS ___________________________

Are you currently under the care of a physician for your skin? Y N
If yes, why? ____

Have you ever seen a dermatologist, or other physician for your skin? Y N
If yes, why? ____

Have you previously had:
Chemical peel? Y N
Type of Peel________________ Date_____________
Laser Resurfacing, Dermabrasion, or Microdermabrasion? Y N
Type/Depth (if known)_______________ Date__________________
Facial Surgery? Y N
Procedure____________________________ Date___________

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Y N
If yes, explain____
What skin care products do you use frequently? ____

Are you taking Accutane®? Y N
If yes, what is the dosage and frequency? ____
Have you ever taken Accutane®Y N If yes, last taken on? _____________________

What topical medications do you use or have you used? Retin-A® Hydroquinone

Other: (this includes topical antibiotics, OTC acne remedies, Hydrocortisone,
etc.)____

Please list any oral medications you currently take:
____
(this includes hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, etc).

Please list any nutritional supplements you take:____

HYPERSENSITIVITY AND SKIN FRAGILITY:
Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, hives, etc) Y N
to: cosmetics fabrics Other: (ie, latex, etc) ____________________________
Do you have any known allergies to anything? Y N
If yes, please list all allergies: (this includes medications, aspirin, food, etc
____
Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc? Y N

FREE RADICAL EXPOSURE

Do you smoke? Y N How much?______________________________
Do you consume alcohol? Y N
Do you have a healthy diet? Y N List any dietary concerns ___________________
Do you exercise? Y N
Do you take vitamins Y N Multi-Vitamins___________________________
Antioxidants _____________________________

FOR WOMEN ONLY

Do you have regular periods? Y N
Are you going through menopause? Y N
Are you pregnant or lactating? Y N
Have you ever been pregnant? Y N
Are you trying to become pregnant? Y N
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Y N

PIGMENTATION (Fitzpatrick Scale):

How do you tan?

I Burn II Usually Brown III Sometimes Burn
IV Rarely Burn V Never Burn-"Brown" VI Never Burn-"Black, Pregnancy Mask Birthmark

What is Nationality (heritage)?
____

VASCULARITY (telangiectasia or broken capillaries):

Nose area Cheek area Chin area Forehead Entire Face

ACNE:

Do you have any history of acne or periodic breakout? Y N
Pimples White heads Blackheads Enlarged Pores
Acne Scars Cysts Flakiness
Do you only experience breakout during or around your menstrual cycle? Y N
Do you always have a pimple or some type of breakout? Y N

FACIAL WRINKLES: Deep Wrinkles Crows Feet Fine Lines

Have you ever been treated with Botox? Collagen? If yes, date of last treatment___________________

SKIN TYPE:

Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely
Is your skin ever shiny a few hours after cleansing? Frequently Occasionally Very Rarely
How often do you experience blackheads or blemishes? Frequently Occasionally Very Rarely
How noticeable are your pores? Very T-Zone Not Very

ABILITY TO HEAL:

Does your skin appear fragile or burn easily? Y N Explain______________
Do you have any problems healing from a cut or burn? Y N Explain______________
Do you have any health problems? Y N Explain______________
Do you ever use depilatories or waxes on your face? Y N If yes, when last used? ____________________
Have you ever had a "cold sore" Y N If yes, when?__________

SUN HISTORY & LIFESTYLE:

Do you work inside? Y N

Occupation:___________________

Are your hobbies done mostly outside? Y N

Hobbies:_____________________

In the past (including childhood) did you live in a sun belt? Y N

Where did you live?____________

In the past have you neglected to use a sunscreen when outdoors? Y N

Do you currently wear a sun protection product all day, everyday? Y N

Are you willing to a sun protection all day, every day? Y N

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? Y N

If yes, who?_______________________________ Anatomical location:_______________________

ARE YOU SEEING ANY DOCTOR FOR ANY REASON? Y N

IF YES, PLEASE EXPLAIN____

HOW Do YOU WANT TO IMPROVE YOUR SKIN?

1.)_______________________________________

2.)_______________________________________

WHAT SPECIFIC AREAS DO YOU WANT TO TREAT? Neck Face Other Chest Back

DO YOU WEAR CONTACT LENSES? Y N

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date: