



Skin Care Assessment

Date: _____ Patient Name: _____

How do you want to improve your skin?:

- Acne
- Fine Lines/Wrinkles
- Skin Texture/Scars
- Brow Spots/Sun Damage
- Flushing of the skin
- Unwanted Hair
- Enlarged Blood Vessels
- Skin laxity
- Other: _____

What is your primary concern today?: _____

Skin Product History

Please list the products you use daily:

Face Wash: _____ Toner: _____ Moisturizer: _____
 Eye Creams: _____ Serums: _____ Other: _____

Skin Procedure History

Have you previously had any of these skin procedures? If Yes, continue:

Microdermabrasion	Date of last: _____	Chemical Peel	Date of last: _____
Phototherapy	Date of last: _____	Laser Resurfacing	Date of last: _____
Radiofrequency	Date of last: _____	Dermabrasion	Date of last: _____
IPL	Date of last: _____	Laser Hair Removal	Date of last: _____
Fraxel	Date of last: _____	Other: _____	Date of last: _____

Yes No Do you use sunblock daily? If Yes, circle area: Face Chest Arms Hands Legs All Over

Yes No Have had any other skin treatments in the past two weeks? List: _____

Yes No Have you used any aggressive exfoliation in the past two weeks? List: _____

Yes No Do you go to the tanning bed? Date of last: _____ Area: _____

Yes No Do you spray tan or use a sunless tanning cream? Date of last: _____ Area: _____

Yes No Are you planning an upcoming vacation in the sun?

Yes No Have you used any of the following in the past 6 weeks?:

- Waxing
- Electrolysis
- Threading
- Plucking/Tweezing
- Depilatories (Nair, Veet, etc.)

Yes No Do you experience prolonged hyperpigmentation (redness) from burns, cuts, and insect bites?

Skin Condition History

Do you have a history of acne or periodic breakouts?	Frequently	Occasionally	Rarely
Does your skin ever flake or feel tight or dry?	Frequently	Occasionally	Rarely
Is your skin every shiny a few hours after cleansing?	Frequently	Occasionally	Rarely
Is your skin sensitive to fragrances?	Frequently	Occasionally	Rarely
Do you work outside?	Frequently	Occasionally	Rarely
Have you ever been diagnosed with Rosacea?	No / If Yes, list treatments: _____		

Please answer the following questions by circling the number which best described you.

My ethnic origin is closest to:	Very Fair (Celtic and Scandinavian)	0
	Fair (Caucasian, light hair, light eyes)	1
	Pale (Caucasian, dark hair, dark eyes)	2
	Olive (Mediterranean, Asian, Native American)	3
	Dark (Middle Eastern, Hispanic, Asian, African)	4
	Very Dark (African)	5
My eye color is:	Light Blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light Brown	3
	Brown	4
My natural hair color as a teenager was:	Red	0
	Blonde	1
	Light Brown	2
	Dark Brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to Reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light Brown	3
	Medium to dark brown	4
	Dark brown to black	5
If I go out into the sun for an hour without sunscreen and have not been in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, when healed no color change	1
	Burn, then turns tan after a few days	2
	Pink, then turns tan	3
	Just tans	4
	Just gets darker	5
	I can't tell a difference	6

For Office Use:

Skin Type:	
Medications:	
Notes:	
Staff Signature:	Date: