

# SKIN EVALUATION

PATIENTS NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE NUMBERS: \_\_\_\_\_ HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

## CIRCLE/CHECK THE CORRECT RESPONSE:

Have you ever seen a Dermatologist for your skin? Yes No  
Are you pregnant or lactating? Yes No  
Are you taking Accutane? Yes No  
Have you ever taken Accutane? Yes No  
What topical medications do you use or have you used? Retin-A Glycolic Acid  
Other: \_\_\_\_\_  
What oral medications do you use or have you used? Tranquilizer Antibiotics  
Hormones/Birth Control Diuretics

## HYPERSENSITIVITY AND FRAGILITY:

Have you ever had a skin allergy? Yes No  
to: Cosmetics Fabrics Aspirin Other: \_\_\_\_\_

## FREE RADICAL EXPOSURE:

Do you smoke? Yes No How much? \_\_\_\_\_  
Do you consume alcohol? Yes No How much? \_\_\_\_\_  
Do you have a regular diet? Yes No How much? \_\_\_\_\_  
Do you exercise? Yes No How much? \_\_\_\_\_  
Do you take vitamins? Yes No Multi-Vitamin \_\_\_\_\_ Other \_\_\_\_\_

## HORMONES:

Do you have regular periods?  
Are you going through menopause? Yes No  
During pregnancy did you ever get hyperpigmentation or masking? Yes No

## PIGMENTATION (FITZPATRICK SCALE):

How do you tan?  
I Burn II Usually Burn III Sometimes Burn  
IV Rarely Burn V Never Burn-“Brown” VI Never Burn-“Black”  
Pigmentation: Even Uneven Birthmark Pregnancy Mask

## VASCULARITY:

Broken Capillaries: Nose Area Cheek Area Chin Area Forehead Entire Face

## ACNE:

Do you have any history of acne or periodic breakout: Yes No  
Pimples White heads Blackheads Enlarger Pores  
Acne Scars Cysts Flakiness

**FACIAL WRINKLES:**

Do you have                      Deep Wrinkles                      Crow Feet                      Fine Lines

**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?	Yes	No
Do you form a thick or raised scar from a cut or burn?	Yes	No
Do you have any health problems?	Yes	No
Do you wax or use depilatories on your face?	Yes	No
Do you ever get cold sores?	Yes	No

**SUN HISTORY & LIFESTYLE:**

Do you work -	Inside	Outside
Are your hobbies done mostly -	Inside	Outside
In the past(including childhood), did you live in a sun belt?	Yes	No
In the past, have you neglected to use a sunblock when outside?	Yes	No

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

Yes                      No

Anatomical location: \_\_\_\_\_

**YOUR EXPECTATIONS:**

\_\_\_\_\_  
\_\_\_\_\_