aesthetic skincare assessment

last name	first name	date of birth
street address	city, state, zip	email address

How did you hear about us? _____Advertisement _____Website _____Current Patient _____Internet/Social Media

_____Family Friend: _____ _____Other: _____

Have you ever received professional skincare and /or medical aesthetics treatments? (please circle) Yes / No
If "Yes", please list treatments and last treatment date : (examples: facial, microdermabrasion, chemical peel, waxing, Botox,/fillers, laser treatment, IPL, laser hair removal, permanent makeup, etc.)

_____

_____

Have you been under the care of any physician, dermatologist or other medical professional within the past year? Yes / No
If yes, please explain:
_____

When was your last skin cancer check/screening with a physician, dermatologist or medical professional: _____

Please list ALL oral medications, supplements and herbal/homeopathic medications (remedies) you are currently taking:

_____

Please list ALL topical medications you are currently using: (examples Retin-A, Hydroquinone, Metrogel, Efudex, Antibiotics, etc)

_____

Please list ALL allergies and skin sensitivities: (examples aspirin/salicylates , sulfa, penicillin, latex, detergents, scents, oils, lotions, marine, collagen, fish, seaweed, milk, peanuts, etc.)

_____

Do you wear contact lenses? Yes / No If "Yes", are you wearing them now? _____

If you wear a hormonal or nicotine patch, please indicate which type and where you wear it: _____

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? _____

How would you rate the overall quality of your skin: POOR FAIR GOOD VERY GOOD EXCELLENT

When exposed to the sun, do you:

ALWAYS BURN USUALLY BURN SOMETIMES BURN RARELY BURN NEVER BURN

Do you smoke? Yes / No If "Yes", how much / often: _____

Do you drink 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", type/ frequency: _____

How much water do you drink per day: _____

Please list all outdoor hobbies and activities that you participate in on a regular basis:

_____

Please describe your current home-care skin regimen including product name and a.m. / p.m. protocol:
Example: CeraVe Moisturizing Cleanser - am and pm, Obagi Vitamin C serum - am, Retin-A – pm, SkinCeuticals SPF 50 – am

_____

_____

_____

What skin concerns do you have and what improvements would you like to see to your skin: _____

_____

_____

Women only: Are you pregnant, lactating or trying to become pregnant? _____

Is there any additional necessary information that your aesthetician should know before beginning your treatment?

_____

_____

NOTES (please leave blank for aesthetician): _____

_____

_____

_____

_____

_____

_____

_____

I (patient) certify that I have acknowledged all of the information provided by me is true and correct. I also understand that some skin conditions may require more than one treatment and /or a prescribed home-care regimen to achieve optimal results.

Patient Signature: _____ Aesthetician Signature: _____

Date: _____ Date: _____