Aesthetic Skin Care Evaluation Form

Personal Information

Name:_____ Date:_____

Phone No.:_____ Alternate Phone No.:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Email:_____

How did you hear about us?_____

What is the reason for your visit today?_____

What special areas of concern do you have?_____

Skin Type & History

Which conditions would you like to improve?

☐ Acne scarring ☐ Broken capillaries ☐ Enlarged pores

☐ Hyperpigmentation ☐ Age spots ☐ Surgical/Facial scars

☐ Acne ☐ Stretch marks ☐ Fine lines & wrinkles

☐ Other:_____

Have you ever had a facial treatment in the past? ☐ Y ☐ N

What was your experience?_____

How would you describe your skin?_____

☐ Normal ☐ Oily ☐ Sensitive

☐ Dry ☐ Combination ☐ Sun Damaged

How would you rate your skin?_____

☐ Always burn ☐ Seldom burns – always tans well

☐ Burns easily – tans slightly ☐ Rarely burns – deep tan

☐ Burns moderately – tans gradually ☐ Never burns – deeply pigmented

Do you experience?_____

☐ Flakiness ☐ Tightness ☐ Redness ☐ Excessive oil

What is your present skin regimen?

☐ Soap and water ☐ Toner ☐ Moisturizer ☐ Sun block

☐ Cleanser ☐ Mask ☐ Exfoliation

☐ Other:_____

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Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?

☐Y ☐N If yes, what are they?_____

Do you blush easily? ☐Y ☐N If yes, what are the contributing factors?

☐Emotions ☐Foods ☐Temperature changes

Other:_____

Do you: ☐Sun bathe? ☐Use a tanning bed? How often?_____

Have you ever had:

☐Peels ☐Cosmetic surgery ☐Laser resurfacing

☐Microdermabrasion ☐BOTOX®

☐Facial surgery ☐Collagen injections

How Recently?_____

Are you under treatment for any current skin condition? ☐Y ☐N

If yes, what condition(s)?_____

Does your skin: ☐Heal quickly ☐Scars ☐Pigments

Do you bruise easily? ☐Y ☐N

Do you get sores/blisters (Herpes Zoster/Shingles)? ☐Y ☐N

What medications/hormone replacement/vitamins do you presently take?_____

_____

_____

Have you ever used:

☐Accutane ☐Topical antibiotics ☐Hydroxy Acids

☐Retin-A ☐Differin ☐Hydroquinone

☐Renova ☐Tazarac

If yes, when and how long?_____

Any personal or family history of cancer? ☐Y ☐N

How would you describe your overall health: ☐Excellent ☐Good ☐Fair ☐Poor

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Women's Questionnaire

Have you taken oral contraceptives? ☐Y ☐N

Are you pregnant or trying to get pregnant? ☐Y ☐N

Are you taking hormone replacement? ☐Y ☐N

Do you experience hormone imbalances? ☐Y ☐N

Men's Questionnaire

Do you shave with: ☐Electric shaver ☐Razor

Do you experience skin breakouts? ☐Y ☐N

Do you have ingrown hair? ☐Y ☐N

Lifestyle & Diet Questionnaire

Is your stress level ☐High ☐Medium ☐Low

Do you normally sleep well? ☐Y ☐N

Do you exercise regularly? ☐Y ☐N

Do you have food intolerances? ☐Y ☐N

If so, what food intolerances do you have?_____

What is the extent of the reaction(s) you may have?_____

Do you follow any special diet? ☐Y ☐N

How many (8oz) glasses of water do you consume daily?_____

How many caffeinated beverages do you consume daily?_____
(Coffee, tea, soft drinks, or energy drinks)

Your practitioner will recommend the appropriate home care products, schedule for future facial treatments or physician referral order to achieve your skin improvement goals.

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Have you had any of the following, past or present?

Acne	☐Y	☐N	When: _____
Allergies	☐Y	☐N	What: _____
Arthritis or Bursitis	☐Y	☐N	
High blood pressure	☐Y	☐N	
Cancer	☐Y	☐N	
Cataracts	☐Y	☐N	
High cholesterol	☐Y	☐N	
Diabetes	☐Y	☐N	
Eczema	☐Y	☐N	Where: _____
Epilepsy	☐Y	☐N	
Heart disease/conditions	☐Y	☐N	
Hepatitis	☐Y	☐N	
HIV/AIDS	☐Y	☐N	
Menopausal	☐Y	☐N	
Metal implants	☐Y	☐N	
Pace maker	☐Y	☐N	
Serious injury	☐Y	☐N	Where: _____
Thyroid	☐Y	☐N	
Do you smoke?	☐Y	☐N	How Long: _____
Do you wear contact lenses?	☐Y	☐N	

Have you ever had a reaction to:

☐Cosmetics	☐Medication	☐Fragrance
☐Metals	☐Food	☐Airborne particles

☐Other: _____