



Patient name _____ Date _____

Birthdate _____ Address _____

Telephone _____ Cell phone _____ Email _____

HAVE YOU EVER HAD THE FOLLOWING:

- Diabetes Bleeding disorder Cancer Lupus Rosacea
 Menopause Sun sensitivity Cold sores Keloids
 Allergies please list _____

MEDICATIONS / MEDICAL TREATMENTS

- Are you currently taking birth control pills? yes no
Do you have an IUD? yes no
Are you pregnant or lactating? yes no
Have you ever taken Accutane? yes no

What medications are you currently taking?

Are you currently under a physician's care for any condition? yes no

If yes, please describe _____

Please describe your history of sun exposure _____

SKIN TYPE

- Sunburn easily Sunburn then tan Usually tan Always tan
 Oily Combination Normal Dry Sensitive

COSMETIC HISTORY

- Facial surgery in the past year Glycolic peels in the past year
 Collagen / Restylane injections Botox injections Blue Light
 Laser hair removal Electrolysis Intense Pulse Light (IPL)

SKIN CARE HISTORY Please indicate by brand name the products that you use for daily skin care:

- Cleanser _____ Moisturizer _____
 Toner _____ Sunscreen _____
 Skin bleacher _____ Anti-aging formula _____
 Scrubs _____ Alpha Hydroxy Acids _____
 Cleanser _____ Moisturizer _____
 Retin-A % _____ Self tanner _____

WHAT CONDITIONS CURRENTLY APPLY TO YOUR SKIN?

- Uneven skin tone Acne / Acne scars Enlarged pores Lip lines Wrinkles
 Hyperpigmentation Facial Hair Facial capillaries Age spots Fine lines

We hereby advise you: to prevent the occurrence of undetected skin cancer, you must have a yearly skin evaluation by a dermatologist.

Signature _____ Date _____