CENTRE for PURE SKIN

Skin Care Assessment

Patient Name:_____ **Age**:_____ **Date**:_____

Have you seen one of the CPS Doctors in the past? Yes No If yes, who?_____

Please list any oral medications you currently take:_____

_____

(please includes hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, photosensitizing drugs, etc.)

Please list any **nutritional supplements** (over the counter) you take:_____
Are you taking **Accutane**? Yes No If yes, what is the dosage and frequency?_____
Have you ever taken Accutane? Yes No If yes, last taken on?_____

Do you have any known allergies ? Yes No Please list all allergies:(this includes medications, food, etc.)

_____

Have you ever had a **skin allergy or sensitivity**? (rash, irritation, peeling, swelling, hives, etc.) Yes No
to: cosmetics fabrics topical anesthetics other: (i.e. latex, etc.)_____

Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, get angry, go in the sun, etc.? Yes No

Do you have any health problems? (heart, lung, kidney, bowel, bladder, diabetes, cancer, etc.) Yes No
If yes, explain_____
Have you ever been told you have Aids/HIV, Hepatitis, MRSA? Yes No _____
Are you seeing a doctor for any reason? Yes No Name:_____
If yes, explain_____
Do you wear contact lenses? Yes No
Have you ever seen a dermatologist; or other physician for your skin? Yes No
If yes, why?_____
Do you smoke? Yes No How much?_____
Do you consume alcohol? Yes No How much?_____
Have you ever had a cold sore? Yes No If yes, when was last one?_____

Have you previously had (circle those that apply to you):

Chemical peel Yes No Type of peel_____ Date(s)_____
Laser Resurfacing Yes No Type/Depth _____ Date(s)_____
MicroDermabrasion? Yes No Type/Depth _____ Date(s)_____
Facial Surgery? Yes No Procedure_____ Date(s)_____

Do you use a Clarisonic Brush or Opal? Yes No
What skin care products do you use frequently (this includes over the counter creams, acne remedies, Hydrocortisone, etc)?

_____

_____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes No
If yes, explain_____
What topical medications do you use or have you used in the past (circle those that apply to you)?
Retin-A Renova Retinol Hydroquinone Glycolic Acid Other_____

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/blemishes?	Frequently	Occasionally	Very Rarely

How noticeable are your pores? Very T-zone Not Very
What is your Nationality (heritage)?_____

Vascularity (telangiectasia or broken capillaries) circle those that apply to you**:**
Nose area Cheek area Chin area Forehead Entire Face

Pigmentation (Fitzpatrick Scale):
Circle the one description that would describe you if you were exposed to strong sun with no sunblock:

I: Always Burn/never tan **II:** Usually Burn/sometimes tan **III:** Sometimes Burn/always tan

IV: Rarely Burn/always tan **V:**Never Burn/moderately pigmented skin **VI:**Never Burn/dark pigmented skin

Pigmentation: Even Uneven Birthmark Pregnancy Mask

Acne:
Do you have any history of acne or periodic breakout? Yes No
Pimples White heads Blackheads Enlarged Pores
Acne scars Cysts Flakiness
Do you experience breakouts during or around your menstrual cycle? Yes No
Do you always have a pimple or some type of breakout? Yes No

Facial Wrinkles (circle those you have)**:** Deep Wrinkles Crows Feet Fine lines
Have you been treated with: Botox Dermal filler If yes, date of last treatment_____

Are you interested in learning more about these services we provide here? Yes No

Ability to heal:
Does your skin appear fragile or burn easily? Yes No If yes, explain_____
Do you have any problems healing from a cut or burn? Yes No If yes, explain_____
Do you ever use depilatories or wax on your face? Yes No If yes, when last used?_____

Sun history & lifestyle:
Do you work inside? Yes No Occupation:_____
Are your hobbies done mostly outside? Yes No Hobbies:_____
In the past (including childhood) did you live in a sun belt? Yes No Where:_____
In the past, have you neglected to use sunscreen when outdoors? Yes No
Do you ever use tanning beds? Yes No
Do you currently wear a sun protection product all day, everyday? Yes No
Are you willing to wear a sun protection all day, everyday? Yes No
Have you or any member of your family had skin cancer? Yes No
If yes, who?_____Anatomical location:_____

For Laser treatment patient's only:
Have you had increase amount of your hair? Yes No Area:_____
Do you have relatives with unwanted hair? Yes No Area:_____
Have you had previous laser or electrolysis treatments: Yes No When:_____
Have you plucked or waxed in the last ten weeks? Yes No When/Area:_____
Do you currently have a tan? Yes No
What specific areas do you want to treat? _____

For Women Only:
Do you have regular periods? Yes No Are you menopausal? Yes No
Are you pregnant or lactating? Yes No If yes, your due date:_____
Are you trying to become pregnant? Yes No Have you ever been pregnant? Yes No
During pregnancy, did you ever experience hyperpigmentation or a "pregnancy mask"? Yes No

When looking in the mirror, I am bothered by my skins (circle): Brown spots Wrinkles Texture Moisture

Other_____

Patient Signature_____Date_____