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, nutritional, and topical medications you currently take, (Please include hormones, birth control pills, antibiotics, nutritional supplements, anti-depressants, diuretics, photosensitizing drugs, Retinols, Retin-A, Hydroquinone, etc.)

_____

_____

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 including medications, food, etc.? Yes / No

Please list all allergies: _____

Do you have any skin allergy or sensitivities? Yes / No

Circle all that apply: cosmetics / fabrics / topical anesthetics / other: (i.e. latex, etc.)_____

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

Please list all known medical problems and illnesses. Be sure to include diabetes, stroke, heart disease, cancer, high blood pressure and bleeding disorders.

_____
Have you ever been told you have HIV/AIDS, Hepatitis, MRSA? Yes / No
Do you wear contact lenses? Yes / No
Have you ever seen a dermatologist or other physician for your skin? Yes / No
If yes, for what condition? _____
Do you smoke? Yes / No How frequently?_____
Do you consume alcohol? Yes / No How frequently?_____
Have you ever had a cold sore? Yes/No If yes, when was last outbreak?_____

Personal History of Acne:
Circle the option best describing how noticeable your pores are. Very / T-zone only / Not Very

Do you have any history of acne or periodic breakouts? Yes / No

Circle all that apply: Pimples / White heads / Blackheads / Enlarged Pores / Acne scars / Cysts / Flakiness

Do your breakouts coincide with your menstrual cycle? Yes / No
Do you almost always have a pimple or some type of breakout? Yes / No

Your Skin's 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? _____

Personal Lifestyle & Sun Exposure History:
Are your hobbies outdoor activities? Yes / No Hobbies: _____
At any time during your past, including childhood, have you experienced repeated damage due to sun exposure? Yes/No
Do you wear sun protection all day, every day? Yes / No
Have you or any member of your family had skin cancer? Yes / No
If yes, who? _____ Anatomical location: _____
Do you use tanning beds? Yes / No
If yes when was the most recent visit? _____

Do you Have Vascularity (broken capillaries)?
Circle those that apply to you:
Nose area / Cheek area / Chin area / Forehead / Entire Face

Personal History of Skin Pigmentation (Fitzpatrick Scale):
Circle the best option describing your skins reaction when 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

Circle the best description of your pigmentation:
Even / Uneven / Birthmark / Melasma

Facial Wrinkles:
Circle any of the types of wrinkles that apply to you:
Deep Wrinkles / Crows Feet / Fine lines

Have you been treated with Botox, Dysport or Dermal fillers? Yes / No If yes, date of last treatment: _____

Personal Skin Care History

Circle any procedures you have had in the past:

Chemical peel / Laser Resurfacing / MicroDermabrasion / Facial Surgery / Microneedling / Microblading

Have you done any aggressive exfoliation to your skin in the last two weeks? Yes/No

If yes, explain_____

What skin care products are you currently using? (This includes over the counter creams, acne remedies, retinols, hydrocortisone, etc.)

_____

Please circle your main skincare concern: Brown spots / Wrinkles / Texture / Moisture / Acne

Other_____

For Women Only:
Do you have regular periods? Yes / No Are you menopausal? Yes / No

Are you trying to become pregnant? Yes / No Have you ever been pregnant? Yes / No

Are you currently pregnant or lactating? Yes / No If yes, when is your due date? _____

During pregnancy, did you ever experience hyperpigmentation or a “pregnancy mask”? Yes / No

Patient Signature_____Date_____

Patient Signature_____Date_____

Patient Signature_____Date_____