SKINETICS®

SKINETICS PATIENT EVALUATION FORM

Patient Name: ____________________________D.O.B:_______ Phone:________________

Address:_____________________________City:_____________Zip:___________________

Have you ever seen a Dermatologist for your skin? Y N
If yes, when and why:____

Have you previously had:
- **Chemical Peel? Y N**
  - **Type of Peel _________________________________Date: __________**
- **Laser Resurfacing, Dermabrasion, MicroDermabrasion? Y N**
  - **Type/Depth (if known) ________________________Date: __________**
- **Facial Surgery? Y N**
  - **Procedure ___________________________________Date: __________**

Are you pregnant or lactating? Y N (If yes, Physician consent is required).
Are you taking Accutane? Y N
Have you ever taken Accutane? Y N

What topical medications/products are you currently using?
- **Retin-A _____ Glycolic Acid ______ Hydroquinone ______**
- **Current Skincare Routine ____**
- **Hydrocortisone ______ Other: ____**

What oral medications are you currently taking?
- **Tranquilizer ______ Antibiotics ______ Hormones/Birth Control ______**
- **Diuretics ______ Other____**

HYPERSENSITIVITY AND FRAGILITY:
Have you ever had a skin allergy? Y N
- **To: Cosmetics ____Fabrics ____Aspirin ____Other_______________**
  - **Do you have sinus sensitivity? Y N**

FREE RADICAL EXPOSURE:

Do you smoke?	**Y**	**N**	**How much? ______________**
Do you consume alcohol?	**Y**	**N**	**How much? ______________**
Do you have a regular diet?	**Y**	**N**	
Do you exercise?	**Y**	**N**	**How much? ______________**
Do you take vitamins?	**Y**	**N**	**Multi-Vitamin ____ Other ____________**

HORMONES: (Female Patients Only)
Do you have regular periods? Y N
Are you going through menopause? Y N
During pregnancy, did you ever experience hyperpigmentation or masking? Y N

PIGMENTATION (Fitzpatrick Scale): Nationality (Optional): ________________________
How do you tan? I Burn ______ II Usually Burn _____III Sometimes Burn _______
IV Rarely Burn _____V Never Burn _____VI Never Burn________
VASCULARITY:
Broken Capillaries: Nose area _____ Cheek area _____ Forehead _____Entire Face______

ACNE:
Do you have any history of acne or periodic breakout? Y N
If yes, how often?____
Pimples _____ White heads _____ Blackheads _____
Enlarged Pores _____ Acne Scars _____ Cysts _____

FACIAL WRINKLES:
Deep Wrinkles _____ Crows Feet _____ Fine Lines _____

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 or blemishes?
Frequently ____ Occasionally ____ Very Rarely ____
How noticeable are your pores? Very___T-Zone____Not Very____

ABILITY TO HEAL:
Does your skin appear fragile or burn easily? Y N
Do you form thick or raised scarring from a cut or burn? Y N
Do you have any health problems? Y N
Do you wax or use depilatories on your face? Y N
Have you ever had cold sores? Y N

SUN HISTORY & LIFESTYLE:
Do you work inside or outside? (Please circle)
Are your hobbies done mostly inside or outside? (Please explain) ______________________
____

Have you or any member of your family had skin cancer? Y N
Anatomical location:____

How would you like to improve your skin and what areas most concern you?
1. ____
2. ____
3. ____

Do you wear contact lenses? Y N
Join our email list____
(We do not solicit or share your personal information.)
How did you hear about our office, so that we may thank the person who referred you. ____

Patient Signature: ______________________________________**Date:** __________________

Aesthetician Signature: ________________________________ Date: _________________