Skin Condition & History Form

Tell us about You!

Today's Date: ____________ **Patient ID #:** ____________

Name: ________________________________ **Home Phone #:** (____)__________
Last First Mi Mr Mrs Ms Dr

Home Address: ________________________________
Street City State Zip

Have you ever seen a Dermatologist for your skin? ❑ Yes ❑ No If yes, what doctor and when ____________
Are you pregnant? ❑ Yes ❑ No ❑ Unsure Week #: ____________
Do you have regular periods? ❑ Yes ❑ No
Are you going through menopause? ❑ Yes ❑ No
Have you ever used Acutane? ❑ Yes ❑ No If yes, when ____________
What topical medications do you use or have you used? ❑ Acne medications ❑ Retin-A ❑ Other ____________
What oral medications are you currently taking? ❑ Tranquilizers ❑ Antibiotics ❑ Hormones ❑ Birth Control ❑ Other ____________
Which skin type best describes your skin: ❑ Normal ❑ Dry ❑ Oily ❑ Combination
Have you ever had a skin allergy? ❑ Yes ❑ No If so, what?
Are you allergic to: ❑ Cosmetics ❑ Fabrics ❑ Aspirin ❑ Other ____________
Do you smoke? ❑ Yes ❑ No
Do you consume alcohol? ❑ Yes ❑ No
Do you have a regular diet? ❑ Yes ❑ No
Do you exercise? ❑ Yes ❑ No
Do you take vitamins? ❑ Yes ❑ No
Do you have pigmented areas (dark spots) on your face that concern you? ❑ Yes ❑ No
Broken Capillaries: ❑ Nose ❑ Cheek ❑ Chin ❑ Forehead ❑ Entire Face
Facial Wrinkles: ❑ Deep Wrinkles ❑ Crows Feet ❑ Fine Lines
How often do you experience blackheads or blemishes? ❑ Frequently ❑ Occasionally ❑ Very Rarely
How noticeable are your pores? ❑ Very ❑ T-Zone ❑ Not Very
How do you tan? ❑ Burn ❑ Burn then Tan ❑ Usually Tan ❑ Always Tan
How much sun exposure do you experience? ❑ A Lot ❑ Moderate ❑ Little
Do you use sun screen? ❑ Yes ❑ No What SPF? ______
Where do you use the sun screen? ❑ Face ❑ Body ❑ Both
Do you form thick or raised scars from a cut or burn? ❑ Yes ❑ No
Do you ever get cold sores or fever blisters? ❑ Yes ❑ No
Do you use wax or depilatories on your face? ❑ Yes ❑ No
Have you ever had skin cancer? ❑ Yes ❑ No
If yes, where and when ____________
Do you have any medical problems? ❑ Yes ❑ No
If yes, what ____________

How do you want to improve your skin? ____________

Have you ever had a face peel by a physician? ❑ Yes ❑ No If yes, when ____________

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