Facial Cosmetic Assessment

Patient Information

First Name ____________________ Last name _________________________________ Date ______________
Sex: ☐Male ☐Female Birth Date ________________ Age______
E-Mail Address ____
Street____________________________________City____________________State_____Zip__________
Home Tel._________________________________Cell____
Have you ever been to our practice? ☐Yes ☐No Referred by ______________________________

Personal History

Are you currently seeing a physician for **any reason**? ☐Yes ☐No
If Yes, explain reason? ____
Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐Yes ☐No
If Yes, when and for what reason?____
Are you **currently** under any other physician's or technician's care for your skin? ☐Yes ☐No
If Yes, detail reason(s)____
Have you or any family member ever had a skin lesion removed by a physician? ☐Yes ☐No
If Yes, who had the lesion removed?_________________ Anatomical location of lesion_____________
Do you have any health problems? **☐Yes ☐No** If Yes, List _____________________________________
____
Do you have glaucoma, peripheral motor neuropathic disease, amyotrophic lateral sclerosis, myasthenia gravis, Lambert-Eaton syndrome, or any other neuromuscular junction disorder? ☐Yes ☐No
Do you have **any** allergies or skin sensitivities? ☐Yes ☐No
If Yes, please list **all** allergies/skin sensitivities____
Do you currently take **any** oral medications (prescriptive pharmaceuticals)? ☐Yes ☐No
(Include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension meds, etc.)
If yes, list all **oral** medications ____
____
Do you use **any** topical medications (prescriptive pharmaceuticals)? ☐Yes ☐No
(Includes Retin-A®, Hydroquinone, Benzoyl peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)
If Yes, list all **topical** medications ____
Have you ever taken an oral retinoid? ☐Yes ☐No
I <u>currently</u> take an oral retinoid: Date Started_____________ Dosage/frequency used________________
I took an oral retinoid in the <u>past</u>: Date Discontinued___________ Dosage/frequency used________________
Have you **ever** had a "COLD SORE"? **☐Yes ☐No** If Yes, when was your last cold sore______________________
Do you ever use depilatories or waxes on your face? **☐Yes ☐No** If Yes, when last used?__________________

<u>For Women Only:</u>

Do you have regular periods? **☐Yes ☐No**
Are you going through menopause? **☐Yes ☐No**
Are you trying to become pregnant? **☐Yes ☐No** Are you in a fertility program? **☐Yes ☐No**
Are you pregnant or lactating? **☐Yes ☐No**
Have you ever been pregnant? **☐Yes ☐No**
If Yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? **☐Yes ☐No**

WHAT ARE YOUR CONCERNS REGARDING YOUR SKIN AND/OR FACIAL APPEARANCE?

____
____
____

Skin Product History

Do you currently use skincare products as a daily regimen? **☐Yes ☐No**
If Yes, list products used____
Have you done any aggressive exfoliation to your skin in the last 2 weeks? **☐Yes ☐No**
If Yes, explain type(s) of exfoliation____

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Cosmetic/Skin Procedure History

Have you previously had any of these skin procedures (treatments)? ☐**Yes** ☐**No** If no, skip this section.

Botox/Dysport/Xeomin ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Juvederm/Restylane/
Boletero/ other fillers ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Latisse ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Microdermabrasion ☐**Yes** ☐**No** Date of last procedure____________________________________

Chemical Peel(s) ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Phototherapy ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Laser Resurfacing ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Radiofrequency ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Dermabrasion ☐**Yes** ☐**No** Type of procedure(s)/date________________________________

Facial Surgery ☐**Yes** ☐**No** Type of surgery(s)/date___________________________________

Additional comments about above procedure(s)____

Oily Skin or Acne

Any acne breakouts? ☐**Blackheads** ☐**Whiteheads** ☐**Enlarged Pores** ☐**Pustules** ☐**Large Pores** ☐**Cysts**

Do you always have a pimple or some type of breakout? ☐**Yes** ☐**No**

Does your skin ever flake or feel tight and dry? ☐**Frequently?** ☐**Occasionally?** ☐**Very Rarely?**

Is your skin ever shiny(oily) a few hours after cleansing**?** ☐**Frequently?** ☐**Occasionally?** ☐ **Very Rarely?**

How noticeable are your pores? ☐ **Very?** ☐**T-Zone Only?** ☐**Not very noticeable?**

Sensitive and Intolerant or Dry Skin

Do you get "flush or reddened" when eating spicy foods, drinking alcohol, being angry, or going in the sun etc.?
☐**Yes** ☐**No**

Does your skin ever get flaky or itch? ☐**Yes** ☐**No** If yes, is it seasonal or all the time?____________

Have you ever been diagnosed with Rosacea? ☐**Yes** ☐**No** If yes, when was the diagnosis made?________

Do you have difficulty healing from a cut or burn? ☐**Yes** ☐**No** If yes, explain________________________________

Have you ever had keloid scarring? ☐**Yes** ☐**No** If yes, explain________________________________

Prematurely Aged and/or Hyperpigmented Skin

Do you have facial wrinkles? ☐Deep wrinkles ☐ Crows feet ☐Fine lines ☐ Skin laxity

Have you had a lot of sun exposure in the past? ☐Yes ☐No

In the past, have you neglected to use sunscreen when outdoors? ☐Yes ☐No

Do you ever use tanning beds? ☐Yes ☐No If yes, when____________________________

Are you willing to wear a sun protection product all day every day? ☐Yes ☐No

Fitzpatrick Scale

(How your skin reacts to sun exposure). How do you tan?

☐I Burn ☐II Usually Burn ☐III Sometimes Burn

☐IV Rarely Burn ☐V Never Burn- "Brown" ☐VI Never Burn-"Black"

Is your Skin Pigmentation (Skin discoloration): ☐Even ☐Uneven ☐Birthmark(s) ☐Pregnancy Mask

What is your Ethnicity and Race (heritage)? ____

Patient Signature:____Date__________________