

BIOMEDIC SKIN EVALUATION

Patient's Name: _____ Age: _____ Date: _____

Have you ever seen a Dermatologist for your skin? YES ____ NO ____

If yes, why? _____

Are you currently under the care of a Dermatologist? YES ____ NO ____

If yes, why? _____

Have you previously had:

➤ Chemical Peel? YES ____ NO ____ Type of Peel _____ Date _____

➤ Laser Resurfacing or Dermabrasion? YES ____ NO ____
○ Type/Depth (if known) _____ Date _____

➤ Facial Surgery? YES ____ NO ____ Procedure _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? YES ____ NO ____

If yes, explain: _____

Are you pregnant or lactating? YES ____ NO ____

Are you taking Accutane? YES ____ NO ____ If yes, dosage and frequency? _____

Have you ever taken Accutane? YES ____ NO ____ If yes, when? _____

What topical medications do you use or have you used? Retin A ____ Hydroquinone ____

Other (Including topical antibiotics, OTC acne remedies, Hydrocortisone, etc.) _____

Please list any oral medications you currently take: _____
(Please include OTC meds, hormones, birth control pills, antibiotics, tranquilizers, anti-depressants, diuretics, etc.)

Please list any nutritional supplements you take: _____

What skin care products do you use frequently? _____

HYPERSENSITIVITY AND SKIN FRAGILITY:

Have you ever had a skin allergy or sensitivity? YES ____ NO ____ (Rash, irritation, peeling, swelling)

To: Cosmetics ____ Fabrics ____ Other ____ (i.e. latex, etc.) _____

Do you have any known allergies to anything? YES ____ NO ____

If yes, please list all allergies: _____
Include any allergy to medications, aspirin, food, etc.)

Do you "flush" or appear "reddened" when you eat spicy food, drink alcohol, get angry, etc.?

FREE RADICAL EXPOSURE:

Do you smoke? YES ____ NO ____ If so, how much? _____

Do you consume alcohol? YES ____ NO ____ If so, how much? _____

Do you have a healthy diet? YES ____ NO ____ List any concerns _____

Do you exercise? YES ____ NO ____ If so, how much? _____

Do you take vitamins? YES ____ NO ____ Multi-Vitamins _____ Antioxidants _____

HORMONES:

Do you have a regular period? YES ____ NO ____

Are you going through menopause? YES ____ NO ____

Have you ever been pregnant? YES ____ NO ____

- If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask?"
YES ____ NO ____

PIGMENTATION (Fitzpatrick Scale):

How do you tan?

Burn ____ Usually Burn ____ Sometimes Burn ____

Rarely Burn ____ Never Burn – "Brown" ____ Never Burn – "Black" ____

Pigmentation: Even ____ Uneven ____ Birthmark ____

What is your Nationality (heritage)? _____

VASCULARITY:

Broken Capillaries: Nose Area ____ Cheek Area ____ Chin Area ____

Forehead ____ Entire Face ____

ACNE:

Do you have any history of acne or periodic breakout? YES ____ NO ____

Pimples ____ Whiteheads ____ Blackheads ____ Enlarges Pores ____

Acne Scars ____ Cysts ____ Flakiness ____

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 develop 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? YES ____ NO ____ If yes, explain: _____

Do you have trouble healing from a cut or burn? YES ____ NO ____ If yes, explain: _____

Do you have any health problems? YES ____ NO ____ If yes, explain: _____

Do you ever use depilatories or waxes on your face? YES ____ NO ____ How often? _____

Have you ever had a "cold sore?" YES ____ NO ____ If yes, when was the last time? _____

SUN HISTORY AND 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 ____

In the past have you neglected to use a sunblock 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 product all day, everyday? YES ____ NO ____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? YES ____ NO ____

➤ Anatomic location: _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1. _____
2. _____
3. _____

WHAT SPECIFIC AREAS DO YOU WANT TO TREAT?

Face ____ Neck ____ Chest ____ Back ____

DO YOU WEAR CONTACT LENSES? YES ____ NO ____

Patient Signature: _____ Date: _____