Dr. K's Med Spa
Wellness and Rejuvenation

Medical Skincare Assessment

PATIENT NAME _____ DATE _____

Date of Birth_____ Do you wear contact lenses? ☐ Yes ☐ No

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

Have you or any family member ever had a skin lesion removed by a physician? ☐ Yes ☐ No

If yes, who had lesion removed? _____ Anatomical location of lesion? _____

Do you have any health problems? ☐ Yes ☐ No If yes, list _____

Do you have **any** allergies or skin sensitivities? ☐ Yes ☐ No

If yes, 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, 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 currently take an oral retinoid: Date discontinued_____ Dosage/frequency used _____

I took an oral retinoid in the past: 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?

Do you smoke? ☐ Yes ☐ No If yes, how much/often? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, frequency/amount? _____

Do you have a healthy diet? ☐ Yes ☐ No List any dietary concerns. _____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____ Type(s) _____

Do you take vitamins? ☐ Yes ☐ No If yes, what type(s)? _____

Do you drink water? ☐ Yes ☐ No If yes, how many glasses per day? _____

For women only:

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

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SKIN PRODUCT HISTORY

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

SKIN PROCEDURE HISTORY

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

Microdermabrasion	☐ Yes ☐ No	Date of last procedure _____
Chemical Peels	☐ Yes ☐ No	Type of procedure(s)/date_____
Phototherapy	☐ Yes ☐ No	Type of procedure(s)/date_____
Laser Resurfacing	☐ Yes ☐ No	Type of procedure(s)/date_____
Radio Frequency	☐ Yes ☐ No	Type of procedure(s)/date_____
Dermabrasion	☐ Yes ☐ No	Type of procedure(s)/date_____
Facial Surgery	☐ Yes ☐ No	Type of surgery(s)/date_____

Other procedures/date? _____
Additional comments about above procedures? _____

OILY SKIN OR ACNE

Any acne breakout? ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large Pores ☐ Cysts
Do you have any history of acne or periodic breakout? ☐ Yes ☐ No If yes, ☐ Now? ☐ In past?
Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No
Do you <u>always</u> have a pimple of 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 "flush or reddened" when eating spicy food, drink alcohol, angry, or go 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? If yes, explain _____

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PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? ☐ Deep wrinkles ☐ Crows feet ☐ Fine lines ☐ Skin Laxity
Have you been treated with: ☐ Botox? ☐ Fillers? If yes, date of last treatment_____
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 If yes, where? _____
In the past have you neglected to use a 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 (discoloration): ☐ Even ☐ Uneven ☐ Birthmark(s) ☐ Pregnancy Mask
What is your ethnicity and Race (heritage)? _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1. _____
2. _____

WHAT SPECIFIC AREAS DO YOU WANT TO TREAT?
☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Other _____

Patient Signature:	**Date:**
Technician Signature:	Date:
D.O. Signature:	Date:

By signing, I hereby authorize the use of my photographs to be published on our website for marketing purposes.

Signature_____ Date: _____