

Today's Date: _____

Skin Care Information Form

Name: _____ Birth date: _____

Are you presently under a physician's care for any current skin condition? _____

If so, for what? _____

Are you pregnant? _____ Are you taking birth control in any form? _____

Are you on hormone replacement? _____ What kind? _____

Check all that apply to you:

smoke drink soft drinks drink coffee

eat a lot of sweets drink tap water drink alcohol

Are you now using or have you ever used accutane? _____ If so, when and for how long? _____

Are you using any form of Retin-A? _____ If so, what kind? _____

Are you using any form of alpha-hydroxy acids? _____ If so, what kind? _____

Do you experience frequent blemishes? _____ How often? _____

Have you ever had any facial surgery? _____ Explain _____

Have you waxed, tweezed or plucked in the last four weeks? _____

Have you had chemical peels, dermabrasion, laser resurfacing or face procedures performed? _____

Please explain:

Have you ever had any skin lesions removed? _____ Please explain _____

Are you using any special treatments (night cream, masks, eye cream)? If so, which ones? _____

How does your skin feel half way through the day? _____

Does your face feel tight and dry after cleansing? _____

What do you use to cleanse your face? _____

What do you use to exfoliate? _____

What do you use to moisturize your face? _____

What irritates your skin? _____

Do you burn easily in the sun? _____

How do you perceive your skin type? [Normal] [Oily] [Dry] [Combination] [Sensitive]

What improvements would you like to see in your skin? _____



Skin analyzed with skinscope:	Yes	No
Photos taken:	Coscam	Camera
Date:	_____	
Post treatment photo taken:	_____	
Tx recommendations		
# txs	_____	of _____
# txs	_____	of _____
# txs	_____	of _____
Recommended Products		
Cleanser	_____	
Serum	_____	
Masque	_____	
Moisturizer	_____	
Tx product 1	_____	
Tx product 2	_____	

Patient signature _____ Date: _____

Consultation performed by: _____

Physician signature _____