DERMATOLOGY & SKIN SURGERY SPECIALISTS

Dermatology & Skin Surgery Specialists
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Cosmetic Assessment

Demographics

PATIENT NAME: LAST FIRST M.I		**SOCIAL SECURITY NUMBER**	
MAILING ADDRESS **STREET OR PO BOX** **APT**		**DATE OF BIRTH**	**GENDER:** FEMALE MALE
CITY **STATE** **ZIP**		**HOME PHONE**	**CELL** **WORK**
HOW DID YOU HEAR ABOUT OUR AESTHETICS SERVICES?		**EMAIL**	
RACE: CAUCASIAN AFRICAN AMERICAN AMERICAN INDIAN ASIAN NATIVE HAWAIIAN PACIFIC ISLANDER OTHER		**ETHNICITY:** NON HISPANIC HISPANIC	

Health History

Do you have any allergies to medications, foods, latex, supplements, etc.? If YES, please list:					
Do you wear contacts?		**Do you smoke?**		**Do you have a history of coldsores? How often? Last out break?**	
Have you taken Accutane?		**If yes, when did you last take it?**			
Current Medications &/or Health concerns:					

Current Skin Care Products

Cleansers and Toners:	
Moisturizer:	**Serums:**
Eye Cream:	**Masks:**
Scrub or Exfoliant:	**SPF:**
Night Cream:	**Topical Rx's:**

Permanent Makeup and Tattoos

Please list any permanent makeup or tattoos: ☐ Eyebrows ☐ Eyeliner ☐ Lip Liner ☐ Full Lips ☐ Areola Reconstruction ☐ Other Date: _____

Women Only

Are you pregnant, trying to become pregnant, or currently breast feeding?		**If you have been pregnant, did you have hyper-pigmentation or a "pregnancy mask" during pregnancy?**

Sensitivity & Pigmentation

Do you have a history of acne breaktouts?

□ Yes □ No

How often do you experience a breakout?

□ Always □ Occasionally (Monthly) □ Rarely □ Perimenstrual only

What kind of breakouts do you have?

□ Pimples □ Blackheads □ Whiteheads □ Pustules □ Cysts □ Acne Scars

When you go out into the sun, do you (Circle one)?

Always Burn (I) Usually Burn (II) Sometimes Burn (III) Rarely Burn (IV) Very Rarely Burn (V) Never Burn (VI)

Do you use tanning beds

□ Yes □ No

When was the last time you used a tanning bed?

Do you regularlly apply sunscreen?

□ Yes □ No

Will you diligently use a sunscreen daily?

□ Yes □ No

How much time do you spend outdoors per week?

□ <5 hrs □ 5-10 hrs □ >10 hrs

Do you have uneven pigmentation?

□ Yes □ No

What kind of pigmentation do you have?

□ Broken Capillaries □ Sun Damage
□ Post Inflammatory Pigmentation

Is your skin shiney by noon?

□ Yes □ No

Does your skin generally feel oily?

□ Yes □ No □ T-Zone

Does your skin feel tight, dry, or flakey?

□ Yes □ No

Do you heal well from a cut?

□ Yes □ No

Areas of Concern

What concerns do you have regarding your skin?

□ Fines Lines / Wrinkles □ Acne / Acne Scarring □ Pigmentation
□ Anti-Aging □ Texture / Tone □ Other _____

What areas would you like to treat?

□ Face □ Neck □ Back □ Decollete □ Other

List in order of importance the TOP 3 changes you would like to address with your skin?

Previous Procedures

Chemical Peels: **Date:**

☐ Yes □ No **Procedure:**

Botox/Dysport: **Date:**

☐ Yes □ No **Procedure:**

Facial Surgery: **Date:**

☐ Yes □ No **Procedure:**

Fillers: **Date:** □ Nasolabial fold

☐ Yes □ No □ Lips □ Cheeks □ Tear Troughs

Laser Resurfacing: **Date:**

☐ Yes □ No **Procedure:**

Dermaplane: **Date:**

☐ Yes □ No **Procedure:**

Laser Hair Removal: **Date:**

☐ Yes □ No **Procedure:**

Microdermabrasion: **Date:**

☐ Yes □ No **Procedure:**

Facial Waxing / Sugaring / Threading **Date:**

☐ Yes □ No **Procedure:**

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while Dermatology & Skin Surgery Specialists contract with many insurance companies, I am financially responsible for all esthetician services. I understand that there is a 24 hour cancellation policy. If I do not call 24 hours in advance to cancel/reschedule a skin care appointment, I will be charged a $30 fee. If I break this policy more than twice, I will be charged the full amount of the treatment scheduled. If I have pre-purchased a package, 1 treatment will be deducted.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:

DATE: