SKIN HISTORY FORM

Patient Name: _____ Date: _____
Address: _____
E-Mail: _____ Phone: (home) _____
BirthDate: _____ Phone: (cell) _____
Family Physician: _____ Care Card# _____
Preferred Method of Contact: _____

Please check the features that best describe your skin. This information is necessary for us to design a treatment plan specifically for you.

__Sun damage	__Brown spots/freckles	__Blackheads	__Oily
__Whiteheads	__Clogged Pores	__Sensitive	__Dull
__Chronic acne	__Fine lines	__Broken capillaries	__Normal
__Scarring	__Dry patches	__Loss of elasticity	__Wrinkles

How would you like to improve your skin?_____

1. Are you currently taking any medications? If yes, please list_____ **Y / N**
2. Do you have any allergies to medication, Cosmetics, Latex, Nickel Sulfur, Bi-Sulphites? **Y / N**
3. Are you taking any antibiotics oral/topical? If yes, please list_____ **Y / N**
4. Have you ever been prescribed Accutane? If yes, please list_____ **Y / N**
5. Have you used waxes or depilatories? **Y / N**
   If yes, how recently?_____ Which area(s)? _____
6. Do you use daily sun protection? **Y / N**
7. When was your last exposure to sun or tanning beds? _____
8. Do you have a history of cold sores (Herpes Simplex)? If yes, how frequently? _____ **Y / N**
9. Do you smoke? **Y / N**
10. Do you have a pacemaker, internal heart defibrillator or metal implants in your body? **Y / N**
11. Have you ever had any cosmetic treatments such as Botox, Fillers, or Cosmetic Surgery? **Y / N**
    If yes, when? _____which area(s)?_____
12. For women: Pregnant? **Y / N** Breast-feeding? **Y / N** Do you have a Hormone imbalance? **Y / N**

Cancellation Policy

Treatments are selected and reserved specifically for your needs, based upon availability. In order to best accommodate all patients, we require two business days notification for changes and cancellations. Inadequate notification of a change or cancellation will result in a cancellation fee.

I understand that optimal results can only be achieved by my keeping the office informed of any changes to my health, and medications, and by following the treatment schedule, instructions for skin care and treatments carefully.

Patient Signature _____ Date _____

Genetic Disposition

Score	0	1	2	3	4
Eye color?	Light blue, Gray, Green	Gray Blue, Hazel	Blue	Dark Brown	Brownish Black
Hair color?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
Color of skin not exposed to sunlight?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles in unexposed areas?	Many	Several	Few	Incidental	none

Total Score for Genetic Disposition:_____

Response to Sunlight

Score	0	1	2	3	4
What happens if you get too much sun?	Painful redness and blisters	Blisters sometimes, then peeling	Burn sometimes, then peeling	Rare Burns	Never had a Burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Will you turn brown within a few hours of sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem

Total Score for Response to Sun:_____

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun, tanning light or creams?	More than 3 months ago	2 – 3 months ago	1 – 2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you expose the area you want treated to the sun, tanning light or creams	Never	Hardly ever	Sometimes	Often	Always

Skin Type Total Score = (Genetic Disposition Score) + (Response to Sun Score) + (Tanning Habits Score)

Skin Type Score =_____ **Fitzpatrick Skin Type**: _____

Skin Type Score	Fitzpatrick Skin Type
0 – 7	I
8 – 16	II
17 – 25	III
26 – 30	IV
> 30	V - IV