THE AESTHETIC CENTER
PLASTIC SURGERY
& MEDICAL SPA

Skin Assessment + Medical History

Name: _____ Sex: ____ Age: _____ Date of Birth: _____
Address: _____ Daytime Phone: _____
City: _____ State: _____ Zip: _____ Cell/Alt. Phone: _____
E-mail: _____ Today's Date: _____
Emergency Contact: _____ Phone: _____
How did you hear about The Aesthetic Surgery Center and/or who referred you: _____

Reason for Consultation/Treatment:

□ Acne
□ Brown spots/sun damage
□ Broken capillaries/rosacea
□ Fine lines or wrinkles
□ Hair removal
□ Microblading
□ Skin laxity
□ Skin texture
□ Scar revision

Skin Questions:

1. How long have you been concerned about this condition/area(s)? _____
2. Are your present skin concern(s) getting more pronounced? _____
3. Have you ever been treated for this concern(s)? □ Yes □ No
   If yes, when? _____ What method? _____
4. Are you currently taking medication for your skin concern(s) □ Yes □ No _____
5. Are you using any topical medications or products to treat your skin condition? □ Topical _____
   □ AHA / Glycolic / Salicylic Acid
   □ Retin-A / Tazorac / Differin
   □ Hydroquinone / Kojic Acid
6. How would you describe your skin? (check all that apply)
   □ Thick
   □ Thin
   □ Sagging
   □ Firm
   □ Wrinkled
   □ Uneven/blotchy
   □ Normal
   □ Dry
   □ Oily
   □ Combination
   □ Acne-prone
   □ Sensitive/Reactive
   □ Dehydrated
   □ Patchy dryness
   □ Rosacea
   □ Melasma (pregnancy mask)
   □ Eczema
   □ Psoriasis
   □ Sun-damaged
   □ Hyperpigmented
   □ Hypopigmented
7. Do you consider yourself: □ Sensitive to touch or pain □ Tolerant □ Resilient □ Not Sure
8. Describe your natural skin tone: (check only one)
   □ Pale
   □ Light
   □ Fair
   □ Medium
   □ Olive
   □ Tan
   □ Brown
   □ Dark Brown
   □ Black
9. Describe your ethnic background for skin typing (i.e. Irish, German, Asian, Hispanic): _____

Skin Condition:

- Have you ever had treatments for pigmented lesions? □ Yes □ No
- Do you form thick or raised scars (keloids) from cuts or burns? □ Yes □ No
- Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? □ Yes □ No
- Have you ever had cold sores or fever blisters? □ Yes □ No
- Do you have any permanent make-up or tattoos in the area of treatment? □ Yes □ No

Sun History and Lifestyle:

- What happens to your skin when exposed to sun for 1 hour <u>without</u> SPF and no base tan? (check only one)
  □ Always burns, never tans (I)
  □ Always burns, sometimes tans (II)
  □ Sometimes burns, always tans (III)
  □ Rarely burns, always tans (IV)
  □ Never burns, always tans (V)
  □ Never burns, black skin color (VI)

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Sun History and Lifestyle:

- When was the last time the area to be treated was exposed to direct sunlight (prolonged exposure), tanning booths or self tanner/spray tan? _____
- Do you use SPF daily? □ Yes □ No SPF_____
- Do you smoke? □ No □ Occasionally □ Less than 1 pack per day □ 1 pack per day □ More than 1 pack per day
- Do you drink alcohol? □ No □ 1-2 drinks per week □ 3-5 drinks per week □ 5+ drinks per week
- Do you wear contact lenses? □ Yes □ No

Medical history:

1. Are you currently under the care of a physician? □ Yes □ No If yes, for what: _____
2. Do you have any of the following?

□ Arthritis	□ Compromised immune system	□ MRSA
□ Any active infection	□ Diabetes	□ Sensitive teeth
□ Bleeding disorders	□ Epilepsy or seizures	□ Skin cancer or irregular moles
□ Bruising	□ Heart disease	□ Skin injury
□ Chronic Migraines	□ Hepatitis	□ Vision deficits/sensitivity to light
□ Cold sores/herpes simplex	□ High blood pressure	□ Other: _____

3. Allergies to any of the following?

□ Lidocaine	□ Aloe Vera	□ Fragrance
□ Adhesives	□ Foods/Nuts	□ Alcohol based products
□ Latex	□ Shellfish	□ Medications _____
	□ Gluten	□ Other: _____

4. Do you currently taking any of the following?

□ Accutane	□ Aspirin or Ibuprofen	□ Insulin
□ Antibiotics	□ Cortisone or steroids	□ Sedatives
□ Anticoagulants	□ Herbal supplements/Vitamins	□ Thyroid medication
□ Antidepressants	□ Hormone/testosterone	□ Other: _____

5. For female patients: Are you pregnant or trying to become pregnant? □ Yes □ No

Previous Cosmetic Procedures: (check all that apply)

- Do you currently get/use any of the following:

□ Facials/HydraFacials	□ Microdermabrasion/Chemical Peels	□ Waxing
□ Electrolysis	□ Depilatories	□ Threading

- Have you ever had laser treatment? □ Yes □ No
  Type of Laser _____
  Describe your skin response: _____
- Have you had a Botox/Dermal Filler Injection(s)? □ Yes □ No How often? _____
- Have you had cosmetic surgery? □ Yes □ No Date? _____
  Describe results/recovery: _____

What non-surgical cosmetic medical procedures would you like to learn more about? (check all that apply)

□ Botox/Dysport	□ IPL/ Photofacial	□ Chemical Peels
□ Dermal Fillers (Restylane, Juvederm)	□ Acne Laser Treatment	□ Microdermabrasion
	□ Laser Skin Tightening	□ Microblading
□ Facial/HydraFacial	□ Laser Hair Removal	□ Other _____

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand it is my responsibility to inform my clinician of any changes in my health conditions while seeking treatment as a patient.