Skin Care Information Form

Name: _____

Check all that apply to you: ___Smoke ___Soft drinks ___Coffee ___Alcohol ___Eat a lot of sweets

Have you had any recent sun/tanning bed exposure?_____ If so, when? _____

Are you now using or have you ever used Accutane/ Acne Medication? _____If so, when and for how long? _____

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

Do you experience frequent blemishes? _____ How often? _____

Have you ever had any facial surgery? _____ Explain: _____

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

Please explain:_____

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, exfoliate and moisturize your face?_____

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

Concerns on Face
(check all that apply)

- ☐ Facial veins
- ☐ Hyperpigmentation/ sun spots
- ☐ Redness/rosacea
- ☐ Large pores
- ☐ Acne
- ☐ Melasma
- ☐ Overall texture
- ☐ Wrinkles
  - ☐ Eyes ☐ Forehead
  - ☐ Neck ☐ Mouth

Patient signature _____Date:_____

Consultation performed by: _____Date:_____