NEW PATIENT PROFILE

PLEASE ANSWER ALL QUESTIONS AND BE AS SPECIFIC AS POSSIBLE. THANK YOU!!!

Name:_____ Age:_____ Date:_____

What is the main reason for your visit today?

What cosmetic treatments have you had previously?
- When?
- For what?
- With what?
- Results?

Please list medications, vitamins, herbs, or tonics that you are taking or applying and the reason / condition for their use?

What topical, oral, or injectable medications are you allergic or sensitive to and how?

Have you had any allergies or sensitivities to skin care products? How?

Daily consumption of alcohol is _____ ounces; caffeine is _____ cups.

I have taken ACCUTANE? YES NO When?
I have a history of acne? YES NO
- When was you last breakout?
- In what areas do you breakout?
- At what age was your acne worse?
- My acne is worse at certain times of the month? YES NO When?
- It is made worse by: ☐ Exercise ☐ Foods ☐ Sun ☐ Stress ☐ Winter ☐ Summer

What makes your acne better?

I did / do smoke. _____ packs per day; x _____ years
I quit smoking (date_____) ☐ I have never smoked!

I have had a fever blister, cold sore, or been diagnosed with herpes virus. YES NO
When was your last breakout? How was it treated?

Skin type (when exposed to sun without protection for about 1 hour)
- ☐ always burns, never tans
- ☐ always burns, sometimes tans
- ☐ sometimes burns, sometimes tans
- ☐ always tans
- ☐ Hispanic / Asian / Mediterranean / Middle Eastern / Black

I was last exposed to the sun /used a tanning booth _____ weeks / months / years ago.
I use chemical tanning lotions. YES NO
I am planning a holiday in the sun in _____.
I use a sunscreen daily. YES NO What SPF rating?
I use the ☐ Sun ☐ Salon ☐ Tanning bed How often?
I have had ☐ bad sunburns; ☐ skin blistering; ☐ sun poisoning. Age(s)_____

I exercise every week. YES NO
Doing what / for how long / how often?

I have maintained my same body weight for the past five (5) years? YES NO

I drink > ½ my weight in ounces of fluid per day. YES NO

I sleep soundly six or more hours per night. YES NO

I am currently or periodically under stress. YES NO How?

I have waxing, electrolysis, or laser hair removal treatments. YES NO
How often? What area?

I have had skin peels before. YES NO
What type? What were the results?

I scar after skin treatments, surgery, or injury?; YES NO
☐ Keloid (thick, hard lump or line); ☐ Hyper (dark); ☐ Hypo (light) pigment; or ☐ stay red

I get ingrown hairs; tiny dilated capillaries; varicose veins; or rosacea. YES NO
In what areas?
How have they been treated in the past?

My skin is sensitive to wind and friction. YES NO

How would you describe your skin? ☐ Dry ☐ Oily ☐ Combination
I have areas of dry, flaky skin. YES NO
Where? Scalp Ears Brow Nose Cheeks Other _____

Several hours after applying makeup I have oily areas. YES NO
Where

I currently use: _____(Brand Name - Skin Care or Makeup)

Product	Brand	Acid (yes/no)	How often	Like it? (yes/no)
☐ Cleansers				
☐ Lotion				
☐ Creams				
☐ Masks				
☐ Moisturizers				
☐ Make up				

Please specify those containing Alpha Hydroxy or glycolic acid and list their percentages, if known.

There is a history of skin cancer or pre-cancer in myself or family members.