Welcome!

Claudia's Body & Skin Care Center

Skin Care History Form

Section I: **Patient Information** Date_______________

Name: ____ I prefer to be called: _________________
Address:
____City:_______________State:_________Zip_______________

Phone (______) _________________ (W) Phone: ______________________ (C) Phone: ___________________

Date of Birth: _______________ E-mail: ____

Section II: **Personal History**

Are you **currently** seeing a physician for any reason? ☐ Yes ☐ No
If yes, explain reason ____
Have you ever seen a physician or technician specifically for a skin problem or skin care? ☐ Yes ☐ No
If yes, when and for what reason? ____
Are you **currently** under any other physician's or technician's care for your skin? ☐ Yes ☐ No
If yes, detail reason(s) ____
Have you or any family member ever had a skin lesion removed by a physician? ☐ Yes ☐ No
If yes, who? ______________________________ Anatomical location of lesion? __________________________
Do you have any health problems? ☐ Yes ☐ No If yes, list ____
Do you have any allergies or skin sensitivities? ☐ Yes ☐ No
If yes, list all ____
Do you currently take any oral medications? ☐ Yes ☐ No
(Includes: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, ect.)
If yes, list all ____
Do you use any topical medications? (prescriptive pharmaceuticals) ☐ Yes ☐ No
(Includes: Retin-A, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel, Efudex, Cortisone, ect.)
If yes, list all ____
Have you ever taken an oral retinoid? ☐ Yes ☐ No
I **currently** take an oral retinoid: Date started _________________ Dosage/frequency used _________________
I took an oral retinoid in the past: Date discontinued ___________ Dosage/frequency used ________________
Have you **ever** had a cold sore? ☐ Yes ☐ No If yes, when was your last cold sore? _____________________
Do you ever use depilatories or waxes on your face? ☐ Yes ☐ No If yes, when last used? ________________
Do you smoke? ☐ Yes ☐ No If yes, how much/how often? ___________________________
Do you consume alcohol? ☐ Yes ☐ No If yes, frequency, how much? ___________________________
Do you have a healthy diet? ☐ Yes ☐ No List any dietary concerns ______________________________
Do you exercise? ☐ Yes ☐ No If yes, how often? ____________________________________
Do you take vitamins? ☐ Yes ☐ No If yes, what types? ___________________________________
Do you drink water? ☐ Yes ☐ No If yes, how many glasses per day? ________________________

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For women only:
Do you have regular periods? ☐ Yes ☐ No
Are you going through menopause? ☐ Yes ☐ No
Are you trying to become pregnant? ☐ Yes ☐ No Are you in a fertility program? ☐ Yes ☐ No
Are you pregnant or lactating? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No
If yes, during pregnancy did you ever experience hyper pigmentation or a "pregnancy mask"? ☐ Yes ☐ No

Section III: **Skin Product History**

Do you currently use skin care products as a daily regimen? ☐ Yes ☐ No
If yes, list products used ____
Have you done any aggressive exfoliation to your skin in the last 2 weeks? ☐ Yes ☐ No
If yes, explain types of exfoliation ____

Section IV: **Skin Procedure History**

Have you previously had any of the following skin procedures (treatments)? ☐ Yes ☐ No If not, skip this section.
Microdermabrasion ☐ Yes ☐ No Date of last procedure _________________________
Chemical Peels ☐ Yes ☐ No Type/date ___________________________________
Phototherapy ☐ Yes ☐ No Type/date ___________________________________
Laser Resurfacing ☐ Yes ☐ No Type/date ___________________________________
Radiofrequency ☐ Yes ☐ No Type/date ___________________________________
Facial Surgery ☐ Yes ☐ No Type/date ___________________________________
Other procedures? ☐ Yes ☐ No Type/date ___________________________________
Comments about the procedures above? ____

Section V: **Oily Skin or Acne**

Any acne breakouts? ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large Pores ☐ Cysts
Do you have any history of acne or periodic breakout? ☐ Yes ☐ No
Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No
Do you **always** have a pimple or some type of break out? ☐ Yes ☐ No
Does your skin ever feel flakey or feel tight and dry? ☐ Frequently ☐ Occasionally ☐ Very rarely
Is your skin ever skinny (oily) a few hours after cleansing? ☐ Frequently ☐ Occasionally ☐ Very rarely
How noticeable are your pores? ☐ Very ☐ T-Zone Only ☐ Not very

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Section VI: **Sensitive and Intolerant or Dry Skin**

Do you "flush or reddened" when eating spicy food, drink alcohol, angry or go out in the sun, ect? ☐ Yes ☐ No
Does your skin ever get flaky or itch? ☐ Yes ☐ No Is it seasonal or all the time? ____________
Have you ever been diagnosed with Rosacea? ☐ Yes ☐ No When was the last diagnosis mode? ______
Do you have difficulty healing from a cut or a burn? ☐ Yes ☐ No Explain ______________________________
Have you ever had keloid scarring? If yes, explain ____

Section VII: **Prematurely Aged and/or Hyperpigmented Skin**

Do you have facial wrinkles? ☐ Deep Wrinkles ☐ Crows Feet ☐ Fine lines ☐ Skin Laxity
Have you been treated with: ☐ Botox ☐ Botox
Do you work inside or outside? ☐ Inside ☐ Outside Occupation ______________________
Are your hobbies mostly outside? ☐ Yes ☐ No Hobbies ____________________________
In the past have you neglected to use sunscreen when outdoors? ☐ Yes ☐ No
Do you ever use tanning beds? ☐ Yes ☐ No
Are you willing to wear sun protection product all day, every day? ☐ Yes ☐ No

Fizpatrick Scale (How your skin reacts to sun exposure.) How do you tan?
☐ I Burn ☐ II Usually ☐ III Sometimes burn
☐ IV Rarely Burn ☐ V Never Burn – "brown" ☐ VI Never burn – "black"

Is your skin pigmentation (skin discoloration):
☐ Even ☐ Uneven ☐ Birthmark(s) ☐ Pregnancy Mask
What is your ethnicity and race? ____

How do you want to improve your skin?

1. ____
2. ____

What specific areas do you want to treat?

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Other ____

Patient Signature: ____ Date: ______________

Technician Signature: ____ Date: _______________