Skincare Evaluation

Name_____ Birthdate _____ Date _____
Phone Number _____ Email _____
Address _____

PERSONAL HISTORY

Do you wear contact lenses? Yes No
Are you under the care of a Physician for any reason? Yes No
If yes, please explain _____
Have you ever seen a Physician or technician specifically for a skincare concern? Yes No
If yes, when and for what reason? _____
Are you currently under any other Physician or technician's care for your skin? Yes No
If yes, please provide details _____
Have you or any family member ever had a skin lesion removed by a Physician? Yes No
If yes, who? _____ Location of the lesion? _____
Do you have any health problems? Yes No
If yes, explain _____

Do you have allergies or sensitivities?	Yes	No	If yes, explain _____
Do you take any medications?	Yes	No	If yes, list _____
Do you use any topical medications?	Yes	No	If yes, list _____
Have you ever taken an oral retinoid?	Yes	No	If yes, provide dates and dosage _____
Have you ever had a cold sore?	Yes	No	If yes, date of last cold sore? _____
Do you use facial depilatories or wax?	Yes	No	If yes, last used? _____
Do you smoke?	Yes	No	If yes, how much, how often? _____
Do you consume alcohol?	Yes	No	If yes, how much, how often? _____
Do you have a healthy diet?	Yes	No	List any dietary concerns _____
Do you exercise?	Yes	No	If yes, type and frequency _____
Do you take vitamins?	Yes	No	If yes, list _____
Do you drink enough water?	Yes	No	How many glasses/ day? _____

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 pregnant or lactating?	Yes	No
If yes, are you in a fertility program?	Yes	No	Have you ever been pregnant?	Yes	No

If yes, during pregnancy did you have hyperpigmentation or pregnancy mask? Yes No

SKIN PROCEDURE HISTORY

Have you previously had:

Microdermabrasion	Yes	No	If yes, type and date _____
Chemical peel	Yes	No	If yes, type and date _____
Phototherapy	Yes	No	If yes, type and date _____
Laser resurfacing	Yes	No	If yes, type and date _____
Radiofrequency	Yes	No	If yes, type and date _____
Dermabrasion	Yes	No	If yes, type and date _____
Facial Surgery	Yes	No	If yes, type and date _____

Other procedures/ date? _____

SKIN PRODUCT HISTORY

Do you use skincare products daily? Yes No If yes, list products _____
Have you exfoliated in last 2 weeks Yes No If yes, list type _____

OILY SKIN OR ACNE

Do you have: Blackheads Yes No Whiteheads Yes No Large Pores Yes No
Pustules Yes No Cysts Yes No
Do you have a history of acne or breakouts? Yes No If yes, when? _____
Do you only experience breakouts during or around your menstrual cycle? Yes No
Do you ALWAYS have a pimple or some type of breakout? Yes No
Does your skin ever flake or feel tight and dry? If yes, how often? _____
Is your skin shiny (oily) a few hours after cleansing? If yes, how often? _____
How noticeable are your pores? _____

SENSITIVE AND INTOLERANT SKIN

Do you flush or get "red" when eating spicy food, drink alcohol, go in the sun, etc.? Yes No
Does your skin get flaky or itch? Yes No If yes, is it seasonal or always? _____
Have you ever been diagnosed with Rosacea? Yes No If yes, when was diagnosis? _____
Do you have slow healing from a cut or burn? Yes No If yes, explain _____
Have you had keloid scarring? Yes No If yes, when _____

PREMATURELY AGED AND/ OR HYPERPIGMENTED SKIN

Do you have: Deep wrinkles Crows feet Fine lines Skin laxity
Have you been treated with: Botox Fillers If yes, when? _____
Do you work inside? Yes No Occupation _____
Are your hobbies outside? Yes No Hobbies _____
Lived in the sun belt any time in your life? Yes No If yes, where, when? _____
Have you neglected to use SPF when outside? Yes No If yes, when? _____
Have you used tanning beds? Yes No If yes, when? _____
Are you willing to wear SPF all day, every day? Yes No

FITZPATRICK SCALE – PLEASE CIRCLE ONE

I Burn II Usually Burn III Sometimes Burn
IV Rarely Burn V Never Burn VI Never Burn
Describe your skin pigment: Even Uneven Birthmark(s) Pregnancy Mask

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

_____
_____

WHAT SPECIFIC ARES DO YOU WANT TO TREAT? – PLEASE CIRCLE ALL THAT APPLY

Face Neck Chest Back Other _____

Initials_____I understand that if I am unable to make my scheduled appointment, Gallas Plastic Surgery reserves the right to charge me up to 50% of the appointment or treatment price.

Patient Signature _____ Date _____

Technician Signature _____ Date _____