ADVANCED
SKIN & VEIN
CARE CENTERS
859-554-0519

Skin Care Consult

Name: _____ DOB: _____

Personal History

Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐ 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): _____

Do you have any allergies or skin sensitivities? ☐ Yes ☐ No
If yes, list all allergies/skin sensitivities: _____

Do you currently take any **oral** medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(includes Oral hormones, birth control pills, antibiotics including monocycline/Tetracycline, hypertension, etc.)
If yes, list all **oral** medications: _____

Do you use any **topical** medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(includes Retin-A, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel, Efudex, Cortisone, etc.)
If yes, list all **topical** medications? _____

Have you ever taken an oral retinoid? ☐ Yes ☐ No
I currently take an oral retinoid: Date discontinued _____ 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 hair removal creams or waxes on your face ☐ Yes ☐ No
If yes, when last used? _____

For women only:

Are you trying to become pregnant? ☐ Yes ☐ No Are you in a fertility program? ☐ Yes ☐ No

Are you pregnant or lactation? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? ☐ Yes ☐ No

Skin Product History

Do you currently use skincare products as a daily regimen? ☐ Yes ☐ No
If yes, list products: _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? ☐ Yes ☐ No
If yes, explain type(s) of exfoliation: _____

Patient Initials:_____

Patient Name: _____

Skin Procedure History

Have you previously had any of these skin procedures (treatments)? ☐ Yes ☐ No If no, skip this section.

Microdermabrasion-Peels	☐ Yes ☐ No	Date of last procedure: _____
Autoimmune Diseases	☐ Yes ☐ No	Date of Diagnosis: _____
Keloids or Scarring	☐ Yes ☐ No	Date of Diagnosis: _____
Laser Treatments	☐ Yes ☐ No	Date of last procedure: _____
Bleeding Disorders	☐ Yes ☐ No	Date of last Diagnosis: _____
Pacemaker-Defibrillator	☐ Yes ☐ No	Date of last procedure: _____
Implants-Facial Surgery	☐ Yes ☐ No	Type of surgery(s)/date: _____

Other procedures/date? _____

Additional comments about above procedure(s): _____

Oily Skin or Acne

Any acne breakout? ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large pores ☐ Cysts

Do you have any history of acne or periodic breakout? ☐ Yes ☐ No If yes: ☐ Now ☐ In past?

Do you always have a pimple or some type of breakout? ☐ Yes ☐ No

Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No

Does your skin ever flake or feel tight and dry? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?

Is your skin every shiny (oily) a few hours after cleansing? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?

How noticeable are your pores? ☐ Very ☐ T-zone only ☐ Not very noticeable

Sensitive and Intolerant or Dry Skin

Do you "flush or redden" when eating spicy food, drink alcohol, angry or going in the sun, etc? ☐ Yes ☐ No

Does your skin ever get flaky or itch? ☐ Yes ☐ No If yes, is it seasonal or all the time? _____

Have you ever been diagnosed with Rosacea? ☐ Yes ☐ No If yes, when was the diagnosis made? _____

Do you have difficulty healing from a cut or burn? ☐ Yes ☐ No If yes, explain: _____

Have you ever had a keloid scarring? If yes, explain: _____

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? ☐ Fillers? If yes, date of last treatment: _____
Do you work inside? ☐ Yes ☐ No Occupation: _____
Are your hobbies done mostly outside? ☐ Yes ☐ No Hobbies: _____
In the past (including childhood) did you live in a sun belt? ☐ Yes ☐ No If yes, where? _____
In the past have you neglected to use a sunscreen when outdoors? ☐ Yes ☐ No
Are you willing to wear a sun protection product all day, every day? ☐ Yes ☐ No
Do you ever use tanning beds? ☐ Yes ☐ No If yes, when? _____

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?
☐ I Burn ☐ II Usually Burn ☐ 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 (heritage)? _____

How Do You Want To Improve Your Skin?

1. _____
2. _____

What Specific Skin Areas Do You Want To Treat?

☐ Face ☐ Neck ☐ Chest Other: _____

I herby certify that the benefits, risks, alternatives, possible success, and complications of the procedures were discussed with me. I have signed cosnent form and I was given verbal and written pre-post treatment guidelines. I will waive the treating entity from any responsiblity if I fail to follow these guidelines.

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date

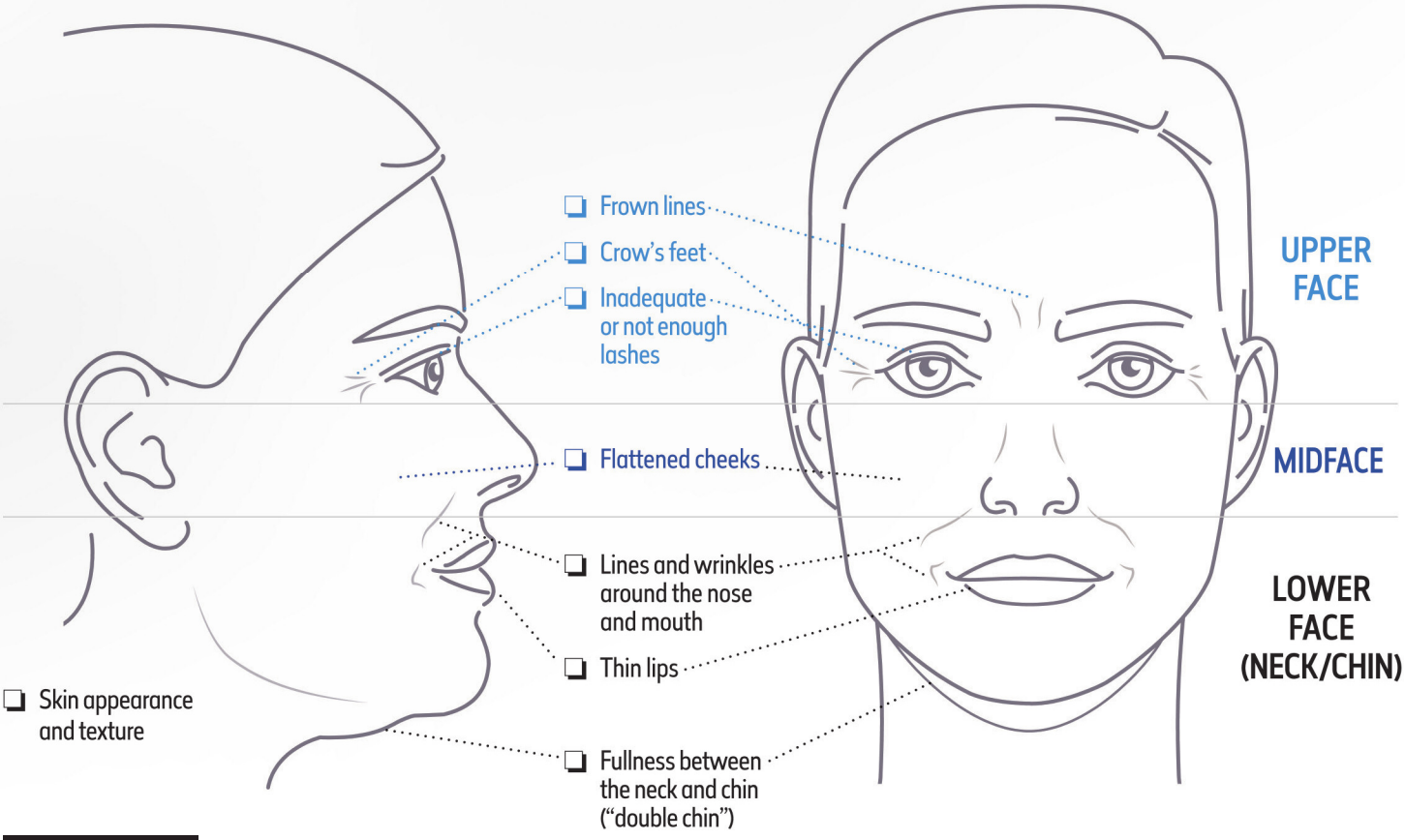
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



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Fitzpatrick Classification Questionnaire

SCORE		0	1	2	3	4
	What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black
	What is the eye color?	Light blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
	What is the color of sun unexposed skin areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 month ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	TOTAL					

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin type V & VI

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