

Date: _____

First Name: _____ **Last Name:** _____

Address: _____ **City, State, Zip:** _____

Home Phone: _____ **Cell Phone:** _____

DOB: _____ **Email:** _____

Reason for visit: _____

Who can we thank for referring you? _____

Have You Ever Seen A Dermatologist For Your Skin? Y N

Are You Taking Accutane? Y N

Have You Ever Taken Accutane? Y N **When?** _____

Do You Use Or Have You Used? Retin-A _____ Glycolic Acid _____

Have You Ever Had, Chemical Peel _____ Laser Resurfacing _____ Facial Surgery _____

What Oral Medications Do You Use Or Have You Used? Antibiotics _____

Diuretics _____ Hormones/Birth Control _____

Does Your Skin Appear Fragile Or Burn Easily? Y N

Do You Form A Thick Or Raised Scar From A Cut OR Burn? Y N

Do You Smoke? Y N **How Much?** _____

Do You Consume Alcohol? Y N **How Much?** _____

Do You Exercise? Y N How Much? _____

Do You Take Vitamins? Y N

Pigmentation: Even _____ Uneven _____ Birthmark _____
Pregnancy Mask _____

Do you: Burn _____ Sometimes Burn _____ Never Burn _____ Usually Burn _____
Rarely Burn _____

Broken Capillaries: Nose Area _____ Cheek Area _____
Chin Area _____ Forehead _____

Do You Have Frequent Break Outs? Y N

Pimples _____ Whiteheads _____ Blackheads _____
Enlarged Pores _____ Cysts _____ Flakiness _____
Acne Scars _____

Is your Skin: Oily _____ Dry _____ Tight _____ Flakiness _____

Do You Ever Get Cold Sores? _____

Do You Spend A Lot Of Time In The Sun? _____

Do You Use Sun Block? Y N SPF# _____

FEMALE PATIENTS

Are You Pregnant Or Breast-Feeding? Y N

Do You Have Regular Periods? Y N

Have You, Or Are You Currently Going Through Menopause? Y N

What Products Are You Currently Using?

Soap _____ Cleanser _____ Toner _____ Glycolic _____ Masque _____
Moisturizer _____ Other: _____

NOTES: (office use only)