AESTHETIC CONSULTATION SKIN ASSESSMENT

NAME:	**BIRTH DATE:**
ADDRESS:	**CITY:**
HOMEPHONE:	**ZIP:**
CELL PHONE:	**REFERRED BY:**
EMAIL:	

What services are you interested in? _____

Please read the following statements. Rate each statement on a ten point scale; 1 means you totally disagree; 10 means that you totally agree. When you think about your skin and its appearance you would say that…….

A. I take skincare seriously and believe my appearance is an important part of who I am.	
B. Beauty and fitness are a personal pursuit in my life.	
C. I seek professional help with my skin care needs (esthetician, physician, salon, spa, or department store beauty and make-up specialists).	
D. It is worth spending a little more money for the very best products for skin care.	
E. I take skin protection and prevention of skin aging very seriously.	
F. I would consider a facelift if and when it is warranted.	

1. WHAT ARE YOUR MAIN CONCERNS? (Check all that apply)

☐ Acne ☐ Acne scarring ☐ Aging ☐ Dry skin ☐ Scars
☐ Enlarged pores ☐ Hyperpigmentation ☐ Spider veins ☐ Fine wrinkles ☐ Deep wrinkles
☐ Cellulite ☐ Dark eye circles ☐ Sagging facial skin ☐ Sun damage/age spots
☐ Uneven skin tone/texture ☐ Preventing skin cancers
☐ Thinning Hair/Eyelashes ☐ Weight ☐ Other_____

2. SKIN TYPE:

☐ Normal ☐ Oily ☐ Sensitive ☐ Dry ☐ Acne Combination
A. How does your skin feel half way through the day?
B. Have you ever had acne or pimples?
C. How long ago was your last break out?
D. Do you burn easily in the sun?
E. Last sun exposure or tanning booth?
F. Do you have any sensitive areas?

3. CURRENT PRODUCTS USED:

Cleansers	☐ Yes	☐ No	Type:
Toners	☐ Yes	☐ No	Type:
Moisturizers	☐ Yes	☐ No	Type:
Sunscreens	☐ Yes	☐ No	Type:
Masks/Scrubs	☐ Yes	☐ No	Type:
Make up	☐ Yes	☐ No	Type:
Self-Tanner	☐ Yes	☐ No	Type:
Retin A	☐ Yes	☐ No	Type:

Alpha Hydroxy Acid	☐ Yes	☐ No	Type:
Hydroquinone	☐ Yes	☐ No	Type:
Other:			

4. MEDICAL HISTORY:

Medication Allergies:			
RX Medications you take:			
Herbal/OTC's you take:			
Are you a smoker?	☐ No	☐ Yes	If yes, how many a day:
Do you have a pacemaker or defibrillator?	☐ No	☐ Yes	
Have you taken Accutane in the last 6 months?	☐ No	☐ Yes	
Do you have a history of keloid scarring?	☐ No	☐ Yes	
Do you have any abnormal/undiagnosed pigmentation?	☐ No	☐ Yes	
Do you have any atypical moles or malignancy?	☐ No	☐ Yes	
Do you have skin cancer/melanoma?	☐ No	☐ Yes	
Do you have any non-intact skin (scars, psoriasis, eczema)?	☐ No	☐ Yes	
Infection or rash?	☐ No	☐ Yes	
Are you healing impaired?	☐ No	☐ Yes	
Do you have Diabetes? Is it Controlled?	☐ No	☐ Yes	
Are you pregnant? Date of Last Menstrual Period.	☐ No	☐ Yes	Date:
Do you have any permanent makeup or tattooing?	☐ No	☐ Yes	If Yes, Where:
Do you have dental crowns, caps, or implants?	☐ No	☐ Yes	If Yes, Where:
History of cold sores?	☐ No	☐ Yes	
Do you have a nickel allergy?	☐ No	☐ Yes	
History of Rosacea?	☐ No	☐ Yes	
History of Psoriasis?	☐ No	☐ Yes	
History of Eczema?	☐ No	☐ Yes	
Are you breast feeding?	☐ No	☐ Yes	

5. PRIOR AESTHETIC/COSMETIC TREATMENTS:

Facials	☐ Yes	☐ No	Type:	
Waxing	☐ Yes	☐ No	Last Treatment:	
Electrolysis	☐ Yes	☐ No	Last Treatment:	
Laser Re-surfacing	☐ Yes	☐ No	Last Treatment:	
Chemical Peel	☐ Yes	☐ No	Last Treatment:	
BOTOX - Dysport - Other	☐ Yes	☐ No	Last Treatment:	Product:
Dermal Filler	☐ Yes	☐ No	When: Product:	Area of Face: Brand Name:
Microdermabrasion	☐ Yes	☐ No	Last Treatment:	
Plastic/Cosmetic Surgery	☐ Yes	☐ No	Where:	

I attest that the above information is true to the best of my knowledge:

Signature: _____ Date: _____