SKIN EVALUATION

NAME: _____ DATE: _____

What skin problems concern you? ☐ Acne ☐ Wrinkles ☐ Red Discoloration ☐ Brown Discoloration

☐ Blackheads ☐ Dry Skin ☐ Textural Changes ☐ Unwanted Hair ☐ Skin Lesions or Spots

Are you currently under a Dermatologist's care? ☐ YES ☐ NO

Reason for Dermatologist _____

WHAT PRODUCTS DO YOU USE IN YOUR DAILY ROUTINE?

AM: _____ PM: _____ **Aesthetician Notes**

Cleanser: _____

Toner: _____

Serum(s): _____

Moisturizer: _____

Topical Prescribed Therapies: _____

Other: _____

PM: _____

Cleanser: _____

Toner: _____

Serum(s): _____

Moisturizers: _____

Mask: _____

Topical Prescribed Therapies: _____

Other: _____

TREATMENT HISTORY:

Have you been treated with a deep peel or dermabrasion? ☐ YES ☐ NO

Have you ever had light peels, facials or other skin treatments? ☐ YES ☐ NO

Have you ever had cosmetic surgery or injections? ☐ YES ☐ NO

Do you use Skin lighteners? ☐ YES ☐ NO

Do you use any acne medications? ☐ YES ☐ NO

FOR FEMALE PATIENTS ONLY:

Are you pregnant or breastfeeding? ☐ YES ☐ NO

Are you planning to become pregnant in the next several months? ☐ YES ☐ NO

Are you using birth control pills? ☐ YES ☐ NO

Are you using hormone replacements? ☐ YES ☐ NO

SIGNATURE:

I certify that the above information is correct, and to the best of my knowledge, accurate and complete. I will notify the doctor of any changes in my heath or medications at my next appointment without fail.

Signature: _____ Date: _____

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