Skin Care By Design
Skin Care History

Name: _____ ***Gender (M or F):*** _____

Address: _____ ***Date of Birth:*** _____

City, State, Zip: _____ ***Occupation:*** _____

Phone: Home: _____ ❑ Confirm appointments to this number by ❑ Call ❑ Text ***Employer:*** _____

Work: _____ ❑ Confirm appointments to this number by ❑ Call ❑ Text ***Emergency Contact:*** _____

Cell: _____ ❑ Confirm appointments to this number by ❑ Call ❑ Text ***Emg Contact Phone:*** _____

Email: _____ ***Relationship:*** _____

Do you want to receive our monthly email newsletter containing exclusive coupons, specials, articles, and event information? ❑ Yes ❑ No ***Referral Source:*** _____

Have you been under the care of a Dermatologist or Plastic Surgeon in the past two years? ❑ Yes ❑ No ***If Yes, Physicians name:*** _____

List all allergies. Include allergies to drugs and medications, foods, cosmetics, skin care products, and textiles: ❑ None

List all medications, vitamins, or supplements you take. Include topical Rx medications such as RetinA or Hydroquinone:

List your current skin care routine, including the products used (morning & evening):

AM _____ **PM** _____

Do you have a history of any of the following conditions? (check all that apply)

- ❑ **Cold Sores**
- ❑ **Herpes Simplex** (not on lips)
- ❑ **Diabetes**
- ❑ **Epilepsy**
- ❑ **Chronic Dizziness**
- ❑ **Chronic Infections**
- ❑ **Chemotherapy**
- ❑ **Radiation Therapy**
- ❑ **Cancer**
- ❑ **Hepatitis**
- ❑ **Fibromyalgia**
- ❑ **Lupus**
- ❑ **Lou Gehrig's Disease**
- ❑ **Myasthenia Gravis**
- ❑ **Prolonged Bleeding**
- ❑ **High Blood Pressure**
- ❑ **Low Blood Pressure**
- ❑ **Have you taken Accutane in the past six months?**
- ❑ **Psoriasis**
- ❑ **Dermatitis**
- ❑ **Rosacea**
- ❑ **Eczema**
- ❑ **Seborrhea**
- ❑ **Acne or Skin Cysts**
- ❑ **Benign Skin Growths**
- ❑ **Excessive Underarm Sweating (Hyperhidrosis)**

Questions about your skin:

Yes	No		Yes	No	
❑	❑	***Do you bruise or bleed easily?***	❑	❑	***Do you blush or flush easily?***
❑	❑	***Do you scar easily?***	❑	❑	***Do injuries such as scrates and insect bites result in dark brown spots?***

Client Name: _____ **Date:** _____

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Describe your exposure and reaction to sunlight:

What best describes your normal sun exposure?

Frequency (check one)
- ❑ Daily
- ❑ Weekends
- ❑ Seasonal

Duration of Each Exposure (check one)
- ❑ Minimal (less than 15 minutes)
- ❑ Moderate (less than 2 hours)
- ❑ Significant (more than 2 hours)

Do you wear sunscreen / sunblock? (check one)
- ❑ Never
- ❑ Rarely
- ❑ Only when outside
- ❑ Always

To what degree does your skin darken or tan after sun exposure? (check one)
- ❑ None (never tans; almost always burns)
- ❑ Barely (rarely tans; usually burns)
- ❑ Light (gradually tans; sometimes burns)
- ❑ Moderate (tans well; rarely burns)
- ❑ Dark (tans darkly; never burns)

How long can you be in the sun without sunscreen before burning? (check one)
- ❑ Less than 15 minutes
- ❑ 15 - 60 minutes
- ❑ 1 - 3 hours
- ❑ 3 - 6 hours
- ❑ Never burn

How sensitive is your skin to the elements and products? (check one)
- ❑ Very sensitive
- ❑ Sensitive
- ❑ Normal
- ❑ Resistant
- ❑ Never had a problem

Do you use tanning booths or tanning beds? ❑ *Yes,* ❑ *No* *Do you use tanning lotions or oils?* ❑ *Yes,* ❑ *No*

Skin cancer information:

Yes	No	
❑	❑	***Have you ever been diagnosed with or treated for skin cancer?***
		*If yes, cancer location?*_____ *Type of cancer?* ❑ *Basal,* ❑ *Squamous,* ❑ *Melanoma*
❑	❑	***Has any member of your family ever been diagnosed with skin cancer?***
		If yes, what is your relationship? _____
❑	❑	***Have you noticed any new pigmented lesions, moles, or dry patches of skin since your last visit?***
		If yes, please describe: _____
❑	❑	***Have you noticed any changes to existing pigmented lesions, moles, or dry patches of skin since your last visit?***
		If yes, please describe: _____

Your natural coloration provides valuable information about your skin:

Your eye color? (check one)
- ❑ Light Blue, Gray, Light Green
- ❑ Blue or Green
- ❑ Light Brown or Hazel
- ❑ Brown
- ❑ Dark Brown
- ❑ Black

Your skin color? (check one)
- ❑ **Very White** (Ivory or Nordic)
- ❑ **White** (Pale)
- ❑ **Olive** (Fair to beige with gold undertones)
- ❑ **Light Brown** (many Hispanics and Asians)
- ❑ **Dark Brown** (many Africans and Asians)
- ❑ **Black** (many Africans and south Asians)

Your natural hair color? (check one)
- ❑ Light/Sandy Red or White Blonde
- ❑ Blonde
- ❑ Auburn or Dark Blonde
- ❑ Light Brown or Chestnut
- ❑ Dark Brown
- ❑ Black

How many freckles appear on skin that is NOT exposed to the sun or UV tanning? ❑ None, ❑ Very Few, ❑ Moderate, ❑ Many

Your family ethnicity and geographic history is important for many skin care treatments:

Please check or list all of the ethnicities, geographic areas, or nationalities that appear on either side of your family tree for the past two or three generations.

Ethnicities
- ❑ Caucasion
- ❑ Hispanic
- ❑ African American
- ❑ Native American
- ❑ Asian
- ❑ South Asian
- ❑ Native Alaskan
- ❑ Pacific Islander

Other: _____ _____

Other: _____ _____

Geographic Areas
- ❑ North America
- ❑ Central America
- ❑ South America
- ❑ Caribbean
- ❑ Africa
- ❑ Scandinavian
- ❑ Europe/West Asia
- ❑ East & Southeast Asia
- ❑ Middle East
- ❑ Australia/Oceania

Other: _____ _____

Countries
- ❑ Ireland and/or Scotland
- ❑ Italy and/or Greece
- ❑ India and/or Pakistan

Other: _____

Other: _____

Other: _____

Are you interested now or in the future in any of these items? (check all that apply and fill in other treatment interests)

- ❑ Botox/Dysport/Xeomin Injections
- ❑ Dermal Filler Injections
- ❑ MicroPen (microneedling) Treatments
- ❑ Chemical/Enzyme Peels
- ❑ Skinceuticals MicroPeel
- ❑ Microdermabrasions
- ❑ Melasma Treatments
- ❑ Stretch Mark Treatments
- ❑ Excessive Underarm Sweating
- ❑ Acne Treatments
- ❑ Cyst Injections
- ❑ Skin Growth Removals
- ❑ Scar Reduction
- ❑ Latisse Eyelash Enhancer
- ❑ Skin Care Products

Other: _____

Other: _____

Laser/IPL/RF Treatments For:
- ❑ Fractional Resurfacing
- ❑ Permanent Hair Reduction
- ❑ Photorejuvenation (including Photofacials)
- ❑ Skin Tightening
- ❑ Spider Veins
- ❑ Rosacea
- ❑ Brown Spots (age or sun spots)
- ❑ Severe or Persistent Acne

Client Name: _____ **Date:** _____