

Patient Profile

Name: _____ DOB: _____ Age: _____ Sex: _____

Do you have any of the following conditions:

active acne uncontrolled diabetes _____ eczema, dermatitis _____
 skin cancer rosacea _____ psoriasis _____

Are you pregnant/lactating?

Do you have permanent makeup? yes no (if so, to what areas of the face?) _____

Do you currently have, or are prone to, cold sores or fever blisters? Yes No

Current medications _____

Allergies/sensitivities _____

Do you have regular Botox, Juvederm, Restylane, Perlane injections? Yes No

Have you had any facial surgery, chemical peels, or laser resurfacing? Yes No

Do you use tanning booths? Yes No Chemical Depilatories? Yes No

What home skin-care products do you currently use? _____

What do you want to improve about your skin?

Fine Lines Frown Lines Acne Scars Marionette Lines
 Color Irregularities Sun Damage Large Pores Worry Lines
 Crow's Feet Deep Smile Lines Facial scars Overall Skin Tone

Describe your skin (check those that apply):

thick thin saggy firm normal dry T-zone/combination
 oily acne blackheads milia cysts breakouts florid
 acne-scarred large pores small pores freckled sun-damaged
 Uneven/blotchy mature wrinkled patchy dryness hypopigmented
 hyperpigmented sallow dehydrated sensitive resilient
 telangiectasia/broken surface capillaries

Skin Pigmentation:

How does your skin react to the sun?

Burns
 Burns, then tans
 Usually tans
 Always tans

Pigmentation

Even
 Uneven
 Birthmarks/freckles
 Pregnancy Mask

The information on this form is correct to the best of my knowledge:

Signature _____ Date _____

Witness _____ Date _____

