

PATIENT PROFILE

NAME: _____ DATE: _____ DOB: _____ DR HERE: _____

PLEASE ANSWER ALL QUESTIONS COMPLETELY

WHY ARE YOU HERE TODAY? PLEASE STATE YOUR SKIN HEALTH CONCERNS OR REASON FOR APPOINTMENT:

PLEASE LIST CURRENT SKIN CARE PRODUCTS (CLEANSERS, MOISTURIZERS, ETC.) INCLUDING OVER-THE-COUNTER PRODUCTS AND PRESCRIPTION SKIN PRODUCTS:

PLEASE LIST ANY DRUG OR PRODUCT ALLERGIES:

ALSO, ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Y	N	Reaction: _____
Dairy/Fruits/Nuts: _____	Y	N	Reaction: _____
Aloe Vera	Y	N	Reaction: _____
Hydroquinone	Y	N	Reaction: _____
Latex	Y	N	Reaction: _____
Minerals/Costume Jewelry/Nickel	Y	N	Reaction: _____

Are you pregnant or lactating?	Y	N	
Do you wear contact lenses?	Y	N	
Have you had recent dental work?	Y	N	Explain/Date: _____
Have you ever had a peel or micropeel?	Y	N	
Have you ever had a microdermabrasion?	Y	N	
Are you using Retin-A/Renova/Differen?	Y	N	Used it in the past? Y N
Are you using Tazorac/Avage?	Y	N	Used it in the past? Y N
Are you using Accutane?	Y	N	Used it in the past? Y N
Do you have any permanent makeup?	Y	N	
Do you get fever blisters or cold sores?	Y	N	
Do you smoke?	Y	N	

ANY FACIAL SURGERY, LASER, BOTOX, FILLERS OR INJECTABLES WITHIN THE PAST WEEK OR SCHEDULED IN THE UPCOMING WEEK? Y N

Explain/Date: _____

ANY BAD REACTION TO A PEEL, MICROPEEL OR MICRODERMABRASION? Y N

Explain/Date: _____

ARE YOU TAKING ANY ANTIBIOTICS OR STEROIDS NOW OR WITHIN THE PAST 2 WEEKS? Y N

State reason for medication: _____

CIRCLE ALL THAT APPLY TO YOUR SKIN:
thick thin lax firm
normal oily dry combination sensitive
acne cysts breakouts large pores small pores
eczema psoriasis rosacea
sun damage pigment capillaries

PLEASE LIST ANY OTHER SKIN CONDITIONS:

