PATIENT PROFILE

NAME:________________________ DATE:__________ DR:______ CHART#_________

WHY ARE YOU HERE TODAY? PLEASE STATE YOUR SKIN HEALTH CONCERNS:

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

PLEASE LIST ANY DRUG OR PRODUCT ALLERGIES:

ALSO, ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Y	N	Reaction:__________
Dairy	Y	N	Reaction:__________
Fruits	Y	N	Reaction:__________
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			
Do you exercise routinely?	Y	N			

ANY RECENT FACIAL SURGERY, LASER, BOTOX, FILLERS OR INJECTABLES? 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? Y N

State reason for medication:______________________________

CIRCLE ALL THAT APPLY TO YOUR SKIN:

CONDITION:
thick thin lax firm
normal oily dry combination sensitive
acne cysts breakouts large pores small pores
eczema psoriasis rosacea
sun damage pigment capillaries