Innovative Aesthetics Skin Assessment

Name: _____ Date: _____

DOB _____ /_____ /_____ Age _____ Sex _____ Occupation _____

Address _____ City _____ STATE _____ ZIP _____

Cell: (____)_____ Home Phone: (____)_____ Business: (____)_____

Email Address _____

(We notify our clients about Monthly Specials, Special Events, and Discounts by e-mail.)

How did you hear about us? _____

(If you were referred by a friend, please include their first & last name so we can credit their account)

Reason for Visit: _____

WE SEND APPOINTMENT REMINDERS VIA EMAIL AND/OR TEXT – PLEASE PROVIDE US WITH THIS INFORMATION TO INSURE APPOINTMENT CONFIRMATION.

Medical History

Are you currently under the care of a physician for any reason? YES NO

If yes, explain: _____

Any known allergies to medication or food? YES NO

If yes, please list: _____

Please list any medical history and surgeries: _____

_____

Are you currently taking any medications? YES NO

If yes, please list: _____

Circle all that Apply: HIV/AIDS HEPATITIS COLD SORES/HERPES MRSA

FEMALES ONLY

Are you pregnant or lactating? YES NO

Are you currently taking any hormonal therapy (birth control, Premarin, estrogen)? YES NO

Have you ever had the "pregnancy mask" or pigment below your eyes, upper lip, or forehead during pregnancy or while on hormonal therapy? YES NO

SKIN

How does your skin reactive to sun exposure?

__ Always Burn __Usually Burn __Sometimes Burn __Rarely Burn __Never Burn (Brown) __ Never Burn (Black)

Do you have a Dermatologist? YES NO Provider's Name: _____

Do you currently use skincare products as a daily regimen? YES NO
If yes, list products used _____
_____

Do you wear sunscreen on a daily basis? YES NO If yes, what brand? _____

Do you use a tanning bed? YES NO

Have you ever had a skin lesion removed by a physician? YES NO

If yes, please explain: _____

OILY SKIN or ACNE

Do you have any history of acne or periodic outbreak? YES NO

Any acne breakout? __Blackheads __Whiteheads __Enlarged Pores __Pustules __Cysts

Do you use or previously used any topical medications for your skin (RetinA, Accutane, Benzoyl Peroxide, Antibiotic, Metrogel, Efudex, Cortisone, etc.) _____

If you have used Accutane, when was your last dose? _____

Is your skin ever shiny (oily) a few hours after cleansing? __Frequently __Occasionally __Very rarely

SENSITIVE AND INTOLERANT SKIN

Do you have any allergies to skin products? _____

What type of reaction do you have (hives, itching, redness, etc.)?_____
Do you "flush or become reddened" when eating spicy food, drink alcohol, or go in the sun? YES NO
Have you ever been diagnosed with Rosacea? YES NO

Do you have difficulty healing from a cut or burn? YES NO

Have you ever had keloid scarring? YES NO

PIGMENTED SKIN

Have you ever been diagnosed with Melasma? YES NO

Are you currently using Hydroquinone or any lightening cream for your pigment? YES NO

Previous Treatments

Have you previously had any of these skin procedures (treatment)?

__Microdermabrasion __Chemical Peels

__Phototherapy __Laser Resurfacing

__Radiofrequency __Facial Surgery

__Botox __Fillers

Other procedures not listed? _____

***CANCELLATION POLICY* – Any appointments cancelled less than 24 hours prior to the scheduled appointment time may be subject to a cancellation fee of up to $50.**

Signature _____ Date _____