PLASTIC SURGERY VEGAS

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Skin Treatment Evaluation

Patients Name: _____ Date: _____

How would you like to improve your skin? _____

Do you have any health problems? Yes No If yes, please explain:

_____

List all current medications, antioxidants, vitamins, or herbal supplements you are taking:

_____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you have any drug or food allergies? Yes No If yes, please explain: _____

_____

Are you pregnant or breastfeeding or are you trying to get pregnant? Yes No

Please list any diagnosed skin conditions and treatment: _____

_____

Do you have a history of skin cancer? Yes No If yes, list location and diagnosis: _____

_____

Do you have a history of cold sores? Yes No Keloid or hypertrophic scarring? Yes No

Skin Type

Please check what best describes your skin type:

- o Very fair skin, always burns
- o Fair skin, usually burns
- o Light skin, burns first then tans
- o Medium skin, usually tans
- o Dark skin, never burns
- o Brown spots
- o Broken capillaries

Do you consider you skin to be? Normal Oily Dry Combination/ T-Zone

Facial wrinkles: None Deep wrinkles Crows feet Fine lines

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Have you or are you currently experiencing acne problems or breakouts? Yes No

Circle all that apply: Pimples Whiteheads Blackheads Enlarged pores Acne scars Cysts

Have you taken the acne medication Accutane? Yes No If yes, when? _____

Do you consider your skin to be sensitive? If yes, explain _____

Sun Exposure

How many hours are you exposed to the sun? _____

Do you travel or live in high altitudes or near water? Yes No

Do you wear sunscreen daily? Yes No If yes, what SPF? _____

Do you sunbathe or use a tanning bed? Yes No

Do you use self-tanner? Yes No

Treatment History

Have you previously had any of the following?

- Chemical peels
- Laser resurfacing
- IPL
- Fraxel
- Facial Surgery
- Microdermabrasion
- Glycolic acid treatments

Type of procedure and dates: _____

Please explain your current skincare regimen and brands of products used:

AM: _____

PM: _____

How long have you been following the above regimen? _____

Are you satisfied with your current products? Yes No

Do you currently use Retinol creams, Retin A, Renova, AHA or glycolic topical preparations? Yes No

If yes, explain strength and frequency:

_____