New patient profile

Please answer all questions and be as specific as possible. Thank you.

Name: ____ Age: ________ Date: _______ / _______ / _______

What is the main reason for your visit today? ____

What cosmetic treatments have you had previously? ____

- When? ____
- For what? ____
- With what? ____

Please list all medications, vitamins, herbs or tonics that you are taking or applying and the reason/condition for their use? ____

____

What topical, oral or injectable medications are you allergic or sensitive to and how?

____

____

Have you had any allergies or sensitivities to skin care products? How? ____

____

Daily consumption of caffeine is ________ cups. Daily consumption of alcohol is ________ ounces.

1. I have taken **ACCUTANE®**. ☐ Yes ☐ No When? ____
2. I have a history of acne. ☐ Yes ☐ No
3. In what areas do you breakout?
4. At what age was your acne worse? ____
5. Is your acne worse at certain times of the month? ☐ Yes ☐ No When? ________________________
6. Acne is made worse by: ☐ Exercise ☐ Foods ☐ Sun ☐ Stres ☐ Winter ☐ Summer
7. What makes your acne better? ____
8. Smoking: ☐ I did/do smoke, ________ packs per day: # ________ years.
   ☐ I quit smoking (date: _______ / _______ / _______).
   ☐ I have never smoked.
9. I have had a fever blister, cold sore, or been diagnosed with herpes virus: ☐ Yes ☐ No
10. When was your last outbreak? _______ / _______ / _______ How was it treated?
11. Skin type: (when exposed to sun without protection for about 1 hour)
    ☐ Always burns, never tans ☐ Always burns, sometimes tans
    ☐ Sometimes burns, sometimes tans ☐ Always tans
12. Please check which best pertains to you:
    ☐ Hispanic ☐ Asian ☐ Mediterranean ☐ Middle Eastern ☐ African American ☐ Caucasian

13. I was last exposed to the sun/used a tanning booth _______ weeks / months / years ago.

14. I used chemical tanning lotions. ☐ Yes ☐ No

15. I am planning a holiday in the sun in ____.

16. I use sunscreen daily. ☐ Yes ☐ No What SPF rating? ______________________________

17. I use the: ☐ Sun ☐ Salon ☐ Tanning bed How often? ______________________________

18. I have had: ☐ Bad sunburns; ☐ Skin blistering; ☐ Sun poisoning Age(s) ____________________

19. I exercise every week. ☐ Yes ☐ No Doing what? ____________ How often? ________________

20. I have maintained my same body weight for the past five (5) years. ☐ Yes ☐ No

21. I drink more than ½ my weight in ounces of fluid per day. ☐ Yes ☐ No

22. I sleep soundly six or more hours per night. ☐ Yes ☐ No

23. I am currently or periodically under stress. ☐ Yes ☐ No

24. I have waxing, electrolysis or laser hair removal treatments. ☐ Yes ☐ No
    How often? __________________ What area? ______________________________

25. I have had skin peels before. ☐ Yes ☐ No
    What type? __________________ What results? ____________________________

26. I scar after skin treatments, surgery or injury. ☐ Yes ☐ No
    If yes: ☐ Keloid (thick, hard dark lump) ☐ Hyper (dark) ☐ Hypo (light) pigment; or stay red.

27. I get ingrown hairs; tiny dilated capillaries; varicose veins; or rosacea. ☐ Yes ☐ No

28. My skin is sensitive to wind and friction. ☐ Yes ☐ No

29. How would you describe your skin? ☐ Dry ☐ Oily ☐ Combination

30. I have areas of dry flaky skin. ☐ Yes ☐ No
    Where? ☐ Scalp ☐ Ears ☐ Brow ☐ Nose ☐ Cheeks ☐ Other: ____________________

31. Several hours after applying makeup I have oily areas. ☐ Yes ☐ No Where? ________________

I currently use:

Product	**Brand**	**Acid**	**How often**	**Like it?**
Cleansers		☐ Yes ☐ No		☐ Yes ☐ No
Lotion		☐ Yes ☐ No		☐ Yes ☐ No
Creams		☐ Yes ☐ No		☐ Yes ☐ No
Masks		☐ Yes ☐ No		☐ Yes ☐ No
Moisturizers		☐ Yes ☐ No		☐ Yes ☐ No
Make up		☐ Yes ☐ No		☐ Yes ☐ No

Please specify those products containing alpha hydroxy or glycolic acid and list their percentage if known.
There is a history of skin cancer or pre-cancer in me or my family members. ☐ Yes ☐ No
If yes, who? ____

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