



GENERAL AESTHETIC CONSULTATION SKIN ASSESSMENT

NAME:	BIRTH DATE:
ADDRESS:	CITY:
HOMEPHONE:	ZIP:
CELL PHONE:	REFERRED BY:
EMAIL:	

What services are you interested in? _____

Please read the following statements. Rate each statement on a ten point scale; 1 means you totally disagree; 10 means that you totally agree. When you think about your skin and its appearance you would say that.....

A. I take skincare seriously and believe my appearance is an important part of who I am.	
B. Beauty and fitness are a personal pursuit in my life.	
C. I seek professional help with my skin care needs (esthetician, physician, salon, spa, or department store beauty and make-up specialists).	
D. It is worth it to spend a little more to get the very best products for skin care.	
E. I take skin protection and prevention of skin aging very seriously.	
F. I would consider a facelift if and when it is warranted.	

1. WHAT ARE YOUR MAIN CONCERNS? (check all that apply)

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Acne scarring | <input type="checkbox"/> Aging | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Spider veins | <input type="checkbox"/> Fine wrinkles | <input type="checkbox"/> Deep wrinkles |
| <input type="checkbox"/> Cellulite | <input type="checkbox"/> Dark eye circles | <input type="checkbox"/> Sagging facial skin | <input type="checkbox"/> Sun damage/age spots | |
| <input type="checkbox"/> Uneven skin tone/texture | <input type="checkbox"/> Preventing skin cancers | | | |
| <input type="checkbox"/> Other: | | | | |

2. SKIN TYPE:

<input type="checkbox"/> Normal	<input type="checkbox"/> Oily	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Dry	<input type="checkbox"/> Acne
A. How does your skin feel half way through the day?				
B. Have you ever had acne or pimples?				
C. How long ago was your last break out?				
D. Do you burn easily in the sun?				
E. Last sun exposure or tanning booth?				
F. Do you have any sensitive areas?				

3. CURRENT PRODUCTS USED:

Cleansers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Toners	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Moisturizers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Sunscreens	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Masks/Scrubs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Make up	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Self-Tanner	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Retin A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:

Alpha Hydroxy Acid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Hydroquinone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Other:			

4. MEDICAL HISTORY:

Medication Allergies:			
RX Medications you take:			
Herbal/OTC's you take:			
Are you a smoker?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many a day?
Do you have a pacemaker or defibrillator?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Have you taken Accutane in the last 6 months?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have a history of keloid scarring?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any abnormal/undiagnosed pigmentation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any atypical moles or malignancy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have skin cancer/melanoma?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any non-intact skin (scars, psoriasis, eczema...)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Infection or rash?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you healing impaired?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have Diabetes? Is it Controlled?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you pregnant? Date of Last Menstrual Period.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date:
Do you have any permanent makeup or tattooing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Where:
Do you have dental crowns, caps, or implants?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, Location:
History of cold sores?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have a nickel allergy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
History of Rosacea?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
History of Psoriasis?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
History of Eczema?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Are you breast feeding?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

5. PRIOR AESTHETIC/COSMETIC TREATMENTS:

Facials	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Waxing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment:
Electrolysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment:
Laser Re-surfacing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment:
Chemical Peel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment:
BOTOX or Dysport	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment: Which Product?
Dermal Filler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: Area of Face? What type? Brand name?
Microdermabrasion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Treatment:
Plastic/Cosmetic Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where:

I attest that the above information is true to the best of my knowledge:

Signature: _____ Date: _____