SKIN CARE HISTORY FORM
DeSpain Cayce Dermatology Center and Medical Spa

Patient:_____ Date:_____
DOB:_____ Chart # _____
Occupation:_____ How Did You Hear About Us?_____

Please circle which skin type (1 to 6) describes you best:

Skin Type	Skin Color	Characteristics
1	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
2	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
3	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
4	Brown; typical Mediterranean caucasian skin	Rarely burns, tans with ease
5	Dark Brown; mid-eastern skin types	very rarely burns, tans very easily
6	Black	Never burns, tans very easily

Do you currently have a sunburn? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑Yes ❑No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No If yes, please describe: _____

What topical medications or creams are you currently using? ❑ Retin-A® ❑ Tazorac ❑ Renova ❑ Avita
❑Others (Please list):_____

What are you looking to improve? List your top 3 cosmetic concerns:

1. _____
2. _____
3. _____

Would you like to discuss skin care products? Y N

Is there any particular treatment(s) you would like to discuss today? _____

History:			**If yes, when?**
Self Tanner	Y	N	_____
Tanned Skin	Y	N	_____
Waxing	Y	N	_____
Tweezing	Y	N	_____
Botox	Y	N	_____
Previous laser treatment	Y	N	_____
Permanent lip/brow tattoo	Y	N	_____
Collagen injections	Y	N	_____
Other cosmetic fillers	Y	N	_____
Chemical Peels	Y	N	_____
Microdermabrasion	Y	N	_____
Facials	Y	N	_____
Gold therapy	Y	N	_____

Have you had any previous cosmetic procedures other than listed above? If yes, please list:

_____

_____

Are you sensitive to any of the following:

Cosmetics	Y	N	Aspirin	Y	N	Lotions/Creams	Y	N
Fabrics	Y	N	Soaps	Y	N	Detergent	Y	N

Social History:

Do you exercise? Y N How often? _____

Do you eat a healthy diet? Y N How often? _____

Do you consume alcohol? Y N How often? _____

What skin care products do you use and what brand?

Soap_____Cleanser_____Toner_____

Masque_____Glycolic /AHA_____Moisturizer_____

Others_____

LASER HAIR REMOVAL Patients Only

What color is the hair at the treatment site:

Black Brown White Grey Red Other_____

What are you currently using/doing to remove hair at the treatment site?

_____

Any Known medical conditions causing increased risk of hair growth? (hormonal abnormalities, Polycystic Ovary Disease, etc.)? If yes, explain: _____

_____

History of any abnormal lab studies to check hormonal levels? Y N

Are you under the care of a Physician? Y N If yes, Explain:_____

_____

Photosensitive Disorders? (ie., lupus, sun rash, hives, etc.)? Y N

Problems with Circulatory System? (ie., Collagen Disease, Raynaud's, Chilblains, etc.) Y N

Previous Laser treatment? Y N

Previous electrolysis? Y N

Are you currently intentionally tanning? (tanning beds, laying out, etc) Y N

Do you wear a broad spectrum sun block every day? Y N

I, _____, attest to the above to be true and accurate. I understand that my technician relies upon this information to provide a safe and effective treatment.

Patient signature: _____

FOR STAFF USE ONLY:

Reviewed by:_____Date:_____