SKIN CARE HISTORY FORM
DeSpain Cayce Dermatology Center and Medical Spa

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

What are you looking to improve? List your top 4 cosmetic concerns:

1. _____ 2._____
3. _____ 4._____

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

Do you currently have a tan? ❑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 ❑Retinol
❑Others (Please list):_____

Would you like to discuss skin care products? Y N

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

_____

Have you had any previous cosmetic procedures? 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?	_____
Do you smoke?	Y	N	How often?	_____

What skin care products do you use and what brand?
Soap_____Cleanser_____Toner_____
Masque_____Glycolic /AHA_____Moisturizer_____
Others_____

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:**_____