SelectSkinMD
SKIN CARE

Patient Profile **Date** _____

Name:_____ **Date of Birth:** _____ **MR#:** _____

1) Are you pregnant or lactating? YES ____ NO ____

2) Do you wear contact lenses? YES ____ NO ____

3) Do you currently have sunburned, windburned or irritated skin? YES ____ NO ____
If so, please specify why: _____

4) Do you sunbathe, tan artificially or spray tan? YES ____ NO ____
If so, when was the last time? _____

5) Do you have a balanced diet, including adequate water intake? YES ____ NO ____

6) Do you smoke or use tobacco? YES ____ NO ____

7) Do you drink alcohol? YES ____ NO ____

8) Do you have any allergies? YES ____ NO ____
If so, please specify allergen and reaction: _____

9) Do you develop cold sores / fever blisters? YES ____ NO ____
If so, please specify last outbreak and reason: _____

10) Do you apply any topical medications to your skin, specifically **Tretinoin** or **Retin-A**? YES ____ NO ____
If so, please specify name, dosage, frequency and time of last application: _____
_____

11) Please specify name, dosage and frequency of any other medications you are currently taking, specifically **Accutane, antibiotics, blood thinners or steroids.** Please include over the counter medications and homeopathic remedies:
_____
_____

12) Have you ever had a chemical peel, laser or light based treatment? YES ____ NO ____
If so, please specify what type, when and where: _____

13) Have you ever had dermal filler or Botox injections? YES ____ NO ____
If so, please specify what type, when and where: _____

14) What does your current skin care regime consist of? Please specify brand name, including active ingredients:
_____

_____

15) What would you like to improve about your skin? _____

Patient's Signature (or that of Parent / Guardian) _____ **Date:** _____

Clinician Signature: _____ **Date:**_____