Dr. Felice's YOUTHFUL iMAGES
It's not about being young. It's about being you.

Medical Evaluation Form

Name _____ **Date**_____

Age_____ **Gender** **M / F** **Height**_____ **Weight**_____

***Allergies—**list both drug & environmental (penicillin, local anesthetic, topical products or **LATEX**)

_____

1. Please describe your reasons for seeking consultation: _____

_____

2. Medical History:

☐ yes ☐ no Skin Disorders: (rashes, burns, scars, cancers)
If yes, please describe _____

☐ yes ☐ no Eyes, Ears (cataracts, glaucoma, tinnitus, hearing impaired, dizziness)
If yes, please describe _____

☐ yes ☐ no Throat (strep throat, difficulties swallowing)
If yes, please describe _____

☐ yes ☐ no Nose (allergies, snoring, sinus infections)
If yes, please describe _____

☐ yes ☐ no Lungs (asthma, emphysema, bronchitis, shortness of breath)
If yes, please describe _____

☐ yes ☐ no Heart (MVP, irregularities, angina, high blood pressure, chest pain)
If yes, please describe _____

☐ yes ☐ no Digestive (indigestion, reflux, ulcers, colitis)
If yes, please describe _____

☐ yes ☐ no Breasts (cysts, pain, nipple discharge, cancer)
If yes, please describe _____

☐ yes ☐ no Pelvic (fibroid, ovarian cysts, cancer)
If yes, please describe _____

☐ yes ☐ no Menstrual Cycle (regular, irregular, degree of cramps, rate of flow)
If yes, please describe _____

☐ yes ☐ no Urinary (bladder infections, bladder control, blood in urine)
If yes, please describe _____

☐ yes ☐ no Neurological (headaches, neck, back or extremity pain/tremors, seizures)
If yes, please describe _____

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☐ yes ☐ no Endocrine (diabetes, hyper/hypothyroidism)

If yes, please describe _____

☐ yes ☐ no Mental Status (anxiety, depression, eating disorder)

If yes, please describe _____

☐ yes ☐ no Bleeding disorders (frequent bruising, abnormal bleeding)

If yes, please describe _____

☐ yes ☐ no Immune (HIV, Herpes/Cold Sores, Hepatitis B/C, etc)

If yes, please describe _____

☐ yes ☐ no Other

If yes, please describe _____

3. Medications:

List all prescription, over the counter and natural supplements with dose and frequency. Include herbs, vitamins and aspirin use.

Medication	***Daily Dosage***
1.	
2.	
3.	
4.	
5.	
6.	

4. Surgery:

List all surgeries with date and any complications:

Surgery	***Date***	***Complications***
1.		
2.		
3.		

5. What type of work do you do? (inside or outside the home, please describe)

_____

6. Do you smoke? (what and how much per day)

_____

7. Do you drink alcohol? (how frequently)

_____

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8. What types of foods do you eat?

9. Family Health History:

List diseases (diabetes, heart disease, cancer etc.)

Siblings or your children	*Maternal Side*	*Paternal Side*

10. Make a list of the various aspects of wellness that are important to you:
(e.g., prevention of disease, aging, mood control, weight control, libido, etc.)

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Clinical Skin Evaluation

Have you ever seen a dermatologist for your skin? ☐ yes ☐ no

Have you ever or are you currently taking any of the following medications?

_____ **Coumadin** _____ **Accutane** _____ **Minocyn** _____ **Aspirin**

If you answered yes, please tell us when?_____

Have you ever had a **skin allergy**? (i.e. cosmetics, fabrics, latex, salicylic or glycolic acids, etc.) ☐ yes ☐ no

If yes, please explain._____

The Parisian Peel Microdermabrasion should be avoided for individuals with **HIV, uncontrolled diabetes, suspected TB or pregnancy**. Is there a possibility that you may have one of these conditions?

_____ Yes _____ No If yes, please explain._____

Would you describe your pigmentation as: Even Uneven Birthmark Pregnancy Mask

Do you have broken capillaries? ☐ yes ☐ no Nose Cheeks Chin Forehead Entire Face

Do you have acne or periodic breakouts? ☐ yes ☐ no

Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars

Do you have: Deep Wrinkles Crows Feet Fine Lines

Do you wear contact lenses? ☐ yes ☐ no

Do you form thick or raised scars from a cut or burn? ☐ yes ☐ no

Do you use a sunblock when outdoors? ☐ yes ☐ no

What SPF do you use? _____

Do you use chemical self-tanning lotions? ☐ yes ☐ no

Have you or members of your family had skin cancer? ☐ yes ☐ no Location _____

Have you ever had any of the following hair removal treatments? bleach electrolysis epilation wax pluck shave

When was your last hair removal treatment? _____

What color is the hair in the area to be treated? _____

Have you had Botox or any type of filler injection within the last 2 weeks? _____ Yes _____ No

Have you undergone Laser Resurfacing with the past 12 weeks? _____ Yes _____ No

Have you had a glycolic or TCA peel within the past 8 weeks? _____ Yes _____ No

How do you wish to improve your skin? _____

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SKIN TYPE

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color.

Please fill this out by circling the ***most appropriate*** response.

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black or Brownish Black
What is the color of your Non-exposed skin?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles in unexposed areas?	Many	Several	Few	Incidental	None

Score	*0*	*1*	*2*	*3*	*4*	*5*	*6*
Which best describes your ancestry?	English, Irish	German, Polish, Swedish	Italian, Spanish, Mediterranean	Jewish, Hispanic, Mexican, French	Asian	Light African American, American Indian	Dark African American

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns
When moderately exposed to the sun, to what degree do you tan?	Hardly or not at all or burn do not tan	Light color tan	Reasonable tan	Tan very easily	Turn dark brown very quickly
After several hours of sun exposure, do you tan?	Never or burn	Seldom	Sometimes	Often	Always
How does you face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Tanning Habits

When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2–3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

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		Skin Type Scale	
◄	Genetic Disposition Score	**I**	**0-7**
◄	Reaction to Sun exposure Score	**II**	**8-16**
◄	Tanning Habits Score	**III**	**17-25**
◄	**Total Score**	**IV**	**26-30**
◄	**Skin Type**	**V-VI**	**Over 30**

I certify that I have completely reviewed the above information for completeness and changes.

Date / Patient Signature

Please list number of question and describe changes.

For Clinician use only:

I certify the supplied information has been reviewed with the patient.

Explanation of all skin care products and post-op instructions were given where applicable. All home care products were reviewed for effectiveness. Any changes and/or concerns were addressed.

Date/Signature