

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? _____

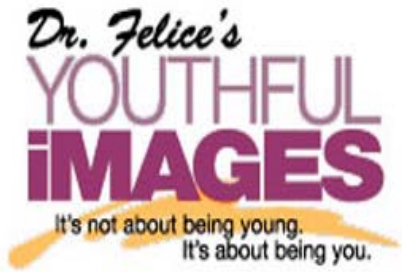
What color is the hair in the area to be treated? _____

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? _____



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

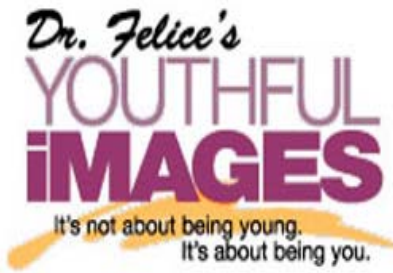
Tanning Habits

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

Office use only:

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
