Body By Leveret

MEDICAL SKINCARE ASSESSMENT

PATIENT'S NAME _____ Date _____
Date of Birth _____ Do you wear contact lenses? ☐ Yes ☐ No
Email: _____

PERSONAL HISTORY

Are you currently seeing a physician for any reason? ☐ Yes ☐ No
If yes, explain reason _____
Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐ Yes ☐ No
If yes, when and for what reason? _____
Are you currently under any other physician's or technician's care for your skin? ☐ Yes ☐ No
If yes, detail reason(s) _____
Have you or any family member ever had a skin lesion removed by a physician? ☐ Yes ☐ No
If yes, who had lesion removed? _____ Anatomical location of lesion? _____

Do you have any health problems? ☐ Yes ☐ No If yes, list _____

Do you have any allergies or skin sensitivities? ☐ Yes ☐ No
If yes, list all allergies/skin sensitivities _____

Do you currently take any oral medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.)
If yes, list all oral medications _____

Do you use any topical medications (prescriptive pharmaceuticals)?
(includes Retin-A®, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)
If yes, list all topical medications _____

Have you ever taken Accutane®? ☐ Yes ☐ No
☐ I currently take Accutane: Dosage prescribed_____ Frequency taken _____
☐ I took Accutane in the past:: Date discontinued_____ Dosage/frequency used _____

Have you ever had a "COLD SORE"? ☐ Yes ☐ No If yes, when was your last cold sore? _____
Do you ever use depilatories or waxes on your face? ☐ Yes ☐ No If yes, when last used? _____

Do you smoke? ☐ Yes ☐ No If yes, how much/often?_____
Do you consume alcohol? ☐ Yes ☐ No If yes, frequency/amount_____
Do you have a healthy diet? ☐ Yes ☐ No List any dietary concerns_____
Do you exercise? ☐ Yes ☐ No If yes, how often? _____ Type(s) _____
Do you take vitamins? ☐ Yes ☐ No If yes, what type(s)? _____
Do you drink water? ☐ Yes ☐ No If yes, how many glasses per day? _____

For women only:
Do you have regular periods? ☐ Yes ☐ No
Are you going through menopause? ☐ Yes ☐ No
Are you trying to become pregnant? ☐ Yes ☐ No Are you in a fertility program? ☐ Yes ☐ No
Are you pregnant or lactating? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? ☐ Yes ☐ No

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? ☐ Yes ☐ No
If yes, list products used _____
How often do you cleanse your face? _____
Have you done any aggressive exfoliation to your skin in the last 2 weeks? ☐ Yes ☐ No
(Retinol, waxing, chemical peel)
If yes, explain type(s) of exfoliation _____

SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? ☐ Yes ☐ No If no, skip this section.

Microdermabrasion	☐ Yes	☐ No	Date of last procedure _____
Chemical Peel(s	☐ Yes	☐ No	Type of procedure(s)/date _____
Phototherapy	☐ Yes	☐ No	Type of procedure(s)/date _____
Laser Resurfacing	☐ Yes	☐ No	Type of procedure(s)/date _____
Radiofrequency	☐ Yes	☐ No	Type of procedure(s)/date _____
Dermabrasion	☐ Yes	☐ No	Type of procedure(s)/date _____
Facial Surgery	☐ Yes	☐ No	Type of surgery(s)/date _____

Other procedures/date? _____
Additional comments about above procedure(s) _____

OILY SKIN OR ACNE

Any acne breakout? ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large pores ☐ Cysts
Do you have any history of acne or periodic breakout? ☐ Yes ☐ No If yes: ☐ Now? ☐ In past?
Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No
Do you always have a pimple or some type of breakout? ☐ Yes ☐No
Does your skin ever flake or feel tight and dry? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?
Is your skin ever shiny (oily) a few hours after cleansing? ☐ Frequently? ☐ Occasionally? ☐ Very rarely?
How noticeable are your pores? ☐ Very? ☐ T-zone only? ☐ Not very noticeable?

SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.? ☐ Yes ☐ No
Does your skin ever get flaky or itch? ☐ Yes ☐ No If yes, is it seasonal or all the time? _____
Have you ever been diagnosed with Rosacea? ☐ Yes ☐ No If yes, when was the diagnosis made? _____
Do you have difficulty healing from a cut or burn? ☐ Yes ☐ No If yes, explain _____
Have you ever had keloid scarring? If yes, explain _____

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? ☐ Deep wrinkles ☐ Crows feet ☐ Fine lines ☐ Skin Laxity
Have you been treated with: ☐ Botox? ☐ Fillers? ☐ If yes, date of last treatment _____
Do you work inside? ☐ Yes ☐ No Occupation _____
Are your hobbies done mostly outside? ☐ Yes ☐ No Hobbies _____
In the past (including childhood) did you live in a sun belt? ☐ Yes ☐ No If yes, where? _____
In the past have you neglected to use a sunscreen when outdoors? ☐ Yes ☐ No
Do you ever use tanning beds? ☐ Yes ☐ No If yes,when? _____
Do you currently wear a sun protection product all day, everyday? ☐ Yes ☐No
Are you willing to wear a sun protection product all day, everyday? ☐ Yes ☐No

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?
☐ **I** Burn ☐ **II** Usually Burn ☐ **III** Sometimes Burn
☐ **IV** Rarely Burn ☐ **V** Never Burn-"Brown" ☐ **VI** Never Burn-"Black"
Is your skin pigmentation (skin discoloration): ☐ Even ☐ Uneven ☐Birthmark(s) ☐ Pregnancy Mask
What is your Ethnicity and Race (heritage)? _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1. _____
2. _____

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Other _____

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date: