



GRAPER
COSMETIC
SURGERY

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Skin Care

Name of Patient: _____

Skin Concerns

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Freckles | <input type="checkbox"/> Port wine stains | <input type="checkbox"/> Vascular lesions/Red spots |
| <input type="checkbox"/> Acne scars | <input type="checkbox"/> Hair Removal | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Lesions/Growths | <input type="checkbox"/> Brown spots | <input type="checkbox"/> Wrinkles | |
| <input type="checkbox"/> Age spots | <input type="checkbox"/> Large pores | <input type="checkbox"/> Scar | |
| <input type="checkbox"/> Birthmarks | <input type="checkbox"/> Laxity | <input type="checkbox"/> Skin texture | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Photoaging | <input type="checkbox"/> Uneven skin tone | |

Skin Concerns Duration

Time

- | | | | | |
|----------------------------|----------------------------|----------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 4 | <input type="checkbox"/> 7 | <input type="checkbox"/> 10 | <input type="checkbox"/> > 12 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 5 | <input type="checkbox"/> 8 | <input type="checkbox"/> 11 | |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 6 | <input type="checkbox"/> 9 | <input type="checkbox"/> 12 | |

Unit

- | | | | |
|-------------------------------|--------------------------------|--------------------------------|---|
| <input type="checkbox"/> Day | <input type="checkbox"/> Week | <input type="checkbox"/> Year | <input type="checkbox"/> Patient unsure |
| <input type="checkbox"/> Days | <input type="checkbox"/> Weeks | <input type="checkbox"/> Years | |

Areas I would like to improve are:

- | | | | |
|--------------------------------------|---|------------------------------------|--------------------------------|
| <input type="checkbox"/> Forehead | <input type="checkbox"/> Around the mouth | <input type="checkbox"/> Underarms | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Browline | <input type="checkbox"/> Lips | <input type="checkbox"/> Arms | <input type="checkbox"/> Back |
| <input type="checkbox"/> Around eyes | <input type="checkbox"/> Chin | <input type="checkbox"/> Hands | |
| <input type="checkbox"/> Cheeks | <input type="checkbox"/> Neck | | |

Current Skin Care (AM/PM) Routine

AM Routine

PM Routine

Cleanser _____	_____
Toner _____	_____
Antioxidant _____	_____
Bleach _____	_____
Retinoid _____	_____
Moisturizers _____	_____
Eye Creams _____	_____
Sunscreens _____	_____
Notes _____	_____

Please list all medications (including aspirin, vitamins and over-the-counter medications) that you are presently taking. If none, write "none."

Name of medication	Reason for medication

Please list allergies, if none, please write "none."

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

What is your ethnic background?

- Caucasian Asian Native American Eastern Mediterranean
 African-American Hispanic Arab Many

HIV Cert

I certify that I am not HIV positive, have AIDS or Hepatitis C.

Is your skin?

- Dry Oily Combination Acne prone

Have you ever had a skin allergy?

Yes No

Do you have a history of acne or periodic breakouts?

Yes No

Have you ever had an adverse reaction after using a skin care regimen?

Yes No

Physical History

	Yes	No	Details
Do you wax or use depilatories on your face?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any active lesions in the last 4-6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had chemotherapy or radiation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had facial surgery, facial peels, laser surgery, Microdermabrasion, recent Botox, Restylane or Juvederm?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you or any member of your family had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you active outdoors?	<input type="checkbox"/>	<input type="checkbox"/>	_____
In the past, have you neglected to use sunscreen when outdoors?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use DAILY sun protection?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear contacts?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your skin fragile or bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you form thick or raised scars?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever seen a Dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take vitamins or food supplements?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of chronic acne?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have a history of skin sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>	_____
HAVE YOU EVER TAKEN ACCUTANE?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>FOR WOMEN ONLY</u>			
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you going through menopause?	<input type="checkbox"/>	<input type="checkbox"/>	_____
During pregnancy, did you get hyperpigmentation or masking?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Check any topic medications (Rx or OTC) you use or have used:

<input type="checkbox"/> Acne	<input type="checkbox"/> Glycolic Acid	<input type="checkbox"/> Differin
<input type="checkbox"/> Retin-A/Renova	<input type="checkbox"/> Tazorac	<input type="checkbox"/> Other _____

Are you currently taking or have you ever used:

<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Birth Control/Hormones	<input type="checkbox"/> Allergy Medications
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Coumadin
<input type="checkbox"/> Diuretics	<input type="checkbox"/> Steroids	<input type="checkbox"/> Aspirin