

# SKIN EVALUATION FORM



Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
E-mail: \_\_\_\_\_ Phone \_\_\_\_\_

This critical information will be used to develop a customized skin treatment plan for you. Please provide the following information.

## Areas of Concern:

What conditions/problem areas would you like improvement in? (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Sun Damage         | <input type="checkbox"/> Clogged Pores   | <input type="checkbox"/> Scarring                      |
| <input type="checkbox"/> Excessive Oiliness | <input type="checkbox"/> Upper Lip Lines | <input type="checkbox"/> Brown Spots/Uneven Skin Color |
| <input type="checkbox"/> Acne/Pimples       | <input type="checkbox"/> Wrinkles        | <input type="checkbox"/> Blackheads/Whiteheads         |
| <input type="checkbox"/> Freckles           | <input type="checkbox"/> Dry Patches     | <input type="checkbox"/> Hard Bumps Under Skin         |

## Skin Condition:

What type of skin do you have?

- Dry     Normal to Dry     Normal     Combination     Oily

When you go out into the sun, do you: (circle one)

- Always Burn (I)**    **Usually Burn (II)**    **Sometimes Burn (III)**    **Rarely Burn (IV)**  
**Very Rarely Burn (V)**    **Never Burn (VI)**

Have you had or planning to have any facial surgery?     Yes     No

What procedures are you interested in? (Please check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Chemical Peels             | <input type="checkbox"/> Microdermabrasion        |
| <input type="checkbox"/> Photo Facials      | <input type="checkbox"/> ReFirme Skin Tightening    | <input type="checkbox"/> Derasound Facial         |
| <input type="checkbox"/> Facials            | <input type="checkbox"/> Lymphatic Drainage Massage | <input type="checkbox"/> Facial Tinting or Waxing |
| <input type="checkbox"/> Botox              | <input type="checkbox"/> Fillers                    | <input type="checkbox"/> Cosmetic Surgery         |

Have you ever been under the treatment plan of the following:    Dermatologist: \_\_\_\_\_ Plastic Surgeon: \_\_\_\_\_  
Esthetician: \_\_\_\_\_

Facial Hair Removal?     Wax     Other    Date: \_\_\_\_\_

Please check the products you are currently using and list the brand names:

Cleanser _____	Sunscreen _____
Moisturizer _____	Toner _____
Eye Cream _____	Mask _____
Scrub _____	Serums _____
Night Cream _____	Astringent _____

## Medical Conditions:

Do you have any chronic skin or medical disorders?     Yes     No

- |                                       |                                     |  |                                  |                                       |   |
|---------------------------------------|-------------------------------------|--|----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Psoriasis    | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Fever Blister | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> Melanoma   | <input type="checkbox"/> Cancer        | <input type="checkbox"/> HIV     | <input type="checkbox"/> Keloid Scars |   |
| <input type="checkbox"/> Other: _____ |                                     |  |                                  |                                       |   |

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# SKIN EVALUATION FORM CONT.



List medications/supplements you are currently using: \_\_\_\_\_

Do they make you sun-sensitive?  Yes  No

Are you allergic to any cosmetic ingredients/medications?  Yes  No

If yes, please list: \_\_\_\_\_

Are you using any of the following:

- Retin A (percentage & how long: \_\_\_\_\_)  Zovirax
- Accutane  Tetracycline
- Oral Contraceptives  Antibiotics (oral/topical)

### Personal Information:

Circle your current level of stress: (low) | 2 3 4 5 6 7 8 9 10 (high)

Circle your normal level of stress: (low) | 2 3 4 5 6 7 8 9 10 (high)

How many ounces of Water do you drink daily? \_\_\_\_\_ Do you take Vitamins or Supplements? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If so, how often: \_\_\_\_\_

Approx. date of your last sunburn: \_\_\_\_\_ Do you use tanning beds? \_\_\_\_\_ If so, how often: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how often: \_\_\_\_\_ Do you live with a smoker? \_\_\_\_\_

Are You Pregnant?  Yes  No Are You Trying to Get Pregnant?  Yes  No

How did you hear about us?

- Website  Friend  Spa Finder  Previous Patient of Dr. Kjar  Referral by Dr.
- Hometown Values  Clipper  Other: \_\_\_\_\_

### TO BE COMPLETED BY ESTHETICIAN

#### Product Recommendations

1. Cleanse: \_\_\_\_\_

2. Anti-Age: \_\_\_\_\_

3. Repair: \_\_\_\_\_

4. Prevent: \_\_\_\_\_

5. Protect: \_\_\_\_\_

Masque: \_\_\_\_\_

Eye Treatment: \_\_\_\_\_

Tyrosinase Inhibitor: \_\_\_\_\_

#### Professional Treatment Recommendations:

Microdermabrasion	SRA	ST
Dermasound	Chem. Peels	DSL
Micro-Peel	Other: _____	

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_