SelectSkinMD
SKIN CARE **Date _____**

LEGAL Name:_____Soc. Sec. #_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

Spouse or Parents/Guardian: _____

Patient's
Mailing Address:_____ City:_____ State:_____ Zip:_____

Seasonal Address: _____ City_____ State:_____ Zip:_____

Home Telephone:_____ Cell Telephone:_____

Employer:_____ Employer Telephone:_____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ Telephone:_____

Regular Physician :_____ City:_____ State:_____

Referral Source:_____

To determine skin type, check one of the following:

TYPE	**SKIN COLOR**	**REACTION TO FIRST SUN EXPOSURE YEARLY**
_____ I	White	always burns / never tans
_____ II	White	usually burns / tans with difficulty
_____ III	White / Asian	sometimes mild burn / average tan
_____ IV	Moderate brown	rarely burns / tans with ease
_____ V	Dark brown	very rarely burns / tans very easily
_____ VI	Black	never burns

I, the undersigned, am aware that I am financially responsible for my charges in full for services and skin care products. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

Patient's name: (please print): _____ Date: _____

Patient's Signature (or that of Parent / Guardian):_____

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SKIN CARE

Patient Profile Date _____

Name:_____ Date of Birth: _____ BX#: _____

1) Are you pregnant or lactating? YES ____ NO ____

2) Do you wear contact lenses? YES ____ NO ____

3) Do you currently have sunburned, windburned or irritated skin? YES ____ NO ____

If so, please specify why: _____

4) Do you sunbathe, tan artificially or spray tan? YES ____ NO ____

If so, when was the last time? _____

5) Do you have a balanced diet, including adequate water intake? YES ____ NO ____

6) Do you smoke or use tobacco? YES ____ NO ____

7) Do you drink alcohol? YES ____ NO ____

8) Do you have any allergies? YES ____ NO ____

If so, please specify allergen and reaction: _____

9) Do you develop cold sores / fever blisters? YES ____ NO ____

If so, please specify last outbreak and reason: _____

10) Do you apply any topical medications to your skin, specifically **Tretinoin** or **Retin-A**? YES ____ NO ____

If so, please specify name, dosage, frequency and time of last application: _____
_____

11) Please specify name, dosage and frequency of any other medications you are currently taking, specifically **Accutane, antibiotics, blood thinners or steroids.** Please include over the counter medications and homeopathic remedies:

_____

12) Have you ever had a chemical peel, laser or light-based treatment? YES ____ NO ____

If so, please specify what type, when and where: _____

13) Have you ever had dermal filler or Botox injections? YES ____ NO ____

If so, please specify what type, when and where: _____

14) What does your current skin care regime consist of? Please specify brand name, including active ingredients:

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15) What would you like to improve about your skin? _____

Patient's Signature (or that of Parent / Guardian) _____ Date: _____
Clinician Signature: _____Date:_____