SPA SKIN EVALUATION FORM

Patient Name: _____ DOB & Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address:

How did you hear about our spa?

☐ Patient Referral: _____ ☐ Friend: _____

☐ Dr. Referral: _____ ☐ Other: _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Facial Surgery

1. Have you had laser resurfacing or other facial procedures in the past 3 months? Yes ☐ No ☐
   If yes, what type and how long ago?
2. Are you planning to have facial resurfacing or surgery in the near future? Yes ☐ No ☐
   If yes, what type and when?

Lifestyle

1. Do you smoke? Yes ☐ No ☐
2. Do you have allergies to any of the following? (check all that apply)
   - ☐ Aspirin
   - ☐ Talc
   - ☐ Clindamycin
   - ☐ Retin-A or Retinoic Acids
   - ☐ Hydroquinone
   - ☐ Other
   - ☐ Beta Hydroxyacids (BHA)
   - ☐ Fragrances
   - ☐ Hydrogen Peroxide
   - ☐ Alpha Hydroxyacids
   - ☐ Sulfa
   - ☐ None Known
3. Do you use RetinA? Yes ☐ No ☐
4. Are you or have you ever used the perscription drug Accutane? Yes ☐ No ☐
   If yes, how long ago?
5. Are you currently on a restricted diet? Yes ☐ No ☐
6. Do you exercise regularly? Yes ☐ No ☐
7. Do you wear contact lenses? Yes ☐ No ☐
8. What temperature water do you use when you cleanse your skin? Cool ☐ Warm ☐ Hot ☐
9. Are you susceptible to cold sores? Yes ☐ No ☐

Moisture Hydration

1. How many 8 oz glasses of water do you drink in a day?
   1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more ☐

Capillary Activity

1. Do you have a tendency to redness in the skin? Yes ☐ No ☐
2. Do you flush easily with heat or embarrassment? Yes ☐ No ☐
3. Have you ever been diagnosed with Rosecea? Yes ☐ No ☐

Skin Quality

1 Describe your facial lines: (check all that apply)
Few to none ☐ Some around the eyes ☐ Around the lips ☐ Around eyes and lips ☐ On forehead and/or cheeks ☐

2 Do you experience eye area puffiness? Yes ☐ No ☐

3 Do you experience dark under eye circles? Yes ☐ No ☐

4 Do you have blackheads and/or whiteheads? Yes ☐ No ☐

5 Is your skin bumpy and uneven in texture? Yes ☐ No ☐

6 Do you have small broken capillaries that show through your makeup? Yes ☐ No ☐

7 Do you have dry patches? Yes ☐ No ☐

8 Describe your skin's pore size:
Enlarged all over ☐ Some enlarged in the T-zone ☐ Nearly invisible ☐

Current Skin Care Products

1. What type of cleanser do you use?
2. Do you wear SPF on a daily basis? Yes ☐ No ☐
   If yes, what level?
3. What product line(s) do you currently use?
4. Have you used glycolic acid products? Yes ☐ No ☐ What percentage?

Men Only

1. Do you dry or wet shave? Wet ☐ Dry ☐ Both ☐ Neither ☐
2. Do you experience irritation from shaving or ingrown hair? Yes ☐ No ☐

Women Only

1. Are you taking oral contraception? Yes ☐ No ☐
2. Are you pregnant, trying to become pregnant or nursing? Yes ☐ No ☐

Oil Secretion

What time of day do you first notice oil or oily sheen?

☐ 15-30 minutes following cleansing
☐ Mid-Afternoon 2-3 pm
☐ Morning 9-10 am
☐ Late Day 4-5 pm
☐ Lunch time 12 pm
☐ Totally Dry, do not experience oiliness

Do you experience skin breakouts? Yes ☐ No ☐

Skin Type

Which of the following best describes your skin type?

☐ Very fair skin tone, blond or redhead, freckles, burns easily, never tans ☐ Light skin tone, will tan, but usually burns

☐ Light to olive skin tone, sometimes burns, hazel eyes, auburn to light brown hair ☐ Medium brown skin tone rarely burns

☐ Dark brown skin tone, very rarely burns, dark eyes, dark hair ☐ Dark skin tone, burn resistant, dark eyes

Almost Done!

	What results are you looking for in your skin?	No	Yes	Additional Comments
1.	Clear up acne eruptions	☐	☐	
2.	Clear up blackheads	☐	☐	
3.	Minimize pore size	☐	☐	
4.	Decrease skin oiliness	☐	☐	
5.	Diminish the appearance of capillaries/redness	☐	☐	
6.	Lighten skin complexion/discoloration/hyperpigmentation	☐	☐	
7.	Restore skin elasticity	☐	☐	
8.	Hydrate the skin	☐	☐	
9.	Smooth skin texture	☐	☐	
10.	Diminish flakiness of skin	☐	☐	
11.	Lighten acne or other scarring	☐	☐	
12.	Diminish wrinkles and fine lines	☐	☐	
13.	No Special Results, just the best regimen for my skin type	☐	☐	

Patient Signature: _____ Date: _____

Consent to Communicate

Patient Name: <PersonalInfo.FirstName> <PersonalInfo.LastName>

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____