CONSULTATION SKIN ASSESSMENT

Name:	Birth Date:
Address:	City:
Home Phone:	Zip:
Cell Phone:	Referred By:
Email:	

WHAT ARE YOUR MAIN CONCERNS? (Check all that apply)

_ Acne
_ Enlarged pores
_ Cellulite
_ Uneven skin tone/texture
_ Thinning hair/Eyelashes
_ PRP Therapy (Joint Pain, Tendonitis, ED, Facial Rejuvenation, Hair Loss)
_ Acne scarring
_ Hyperpigmentation
_ Dark eye circles
_ Deep wrinkles
_ Sun damage/age spots
_ Aging
_Spider veins
_ Dry skin
_ Preventing skin cancers
_ Sagging facial skin
_ Scars
_ Fine wrinkles
_ Hair removal
_ Rejuvapen Micro Needling with PRP

FITZPATRICK CLASSIFICATION OF SKIN TYPE

Scoring	0	1	2	3	4	Points
Natural Hair Color	Sandy Red	Blonde	Chestnut Dark Blonde	Dark Brown	Black	
Eye Color	Light blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black	
Natural Skin Color	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Number of freckles on unexposed skin	Many	Several	Few	Incidental	None	
Skin after being in the sun TOO long without sunblock	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem	
Do you tan?	Rarely or not at all	Light color tan	Reasonably tan	Tan very easy	Turn dark quickly	
Face sensitivity	Very sensitive	Sensitive	Normal	Resistant	Never had a problem	
When was your last sun exposure?	More than 3 months	2-3 months	1-2 months	less than 1 month	Less than 2 weeks	
Do you expose the treatment area to sun?	Never	Hardly ever	Sometimes	Often	Always	
					Total	

SKIN TYPE: ☐ Normal ☐ Oily ☐ Sensitive ☐ Dry ☐ Acne ☐ Combination

CURRENT PRODUCTS USED:

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GRAHAM
MEDICAL AESTHETICS

PRIOR AESTHETIC / COSMETIC TREATMENTS:

	YES	NO			YES	NO	
Facials				BOTOX-Dysport-Other			
Waxing				Dermal Filler			
Electrolysis				Microdermabrasion			
Laser Re-surfacing				Plastic/Cosmetic Surgery			
Chemical Peel				Other			

MEDICAL HISTORY

Medication Allergies:					
RX Medications you take:					
Herbal/OTC's you take:					
	Yes	No		Yes	No
Infection or rash?			Are you healing impaired?		
History of cold sores?			Do you have Diabetes?		
History of Rosacea?			If Diabetic, is it controlled?		
History of Psoriasis?			Do you have any permanent makeup or tattooing?		
History of Eczema?			If Yes, where?		
Do you have a nickel allergy?			Do you have dental crowns, caps, or implants?		
Do you have any non-intact skin? (scars, psoriasis, eczema)			If Yes, Where?		
Do you have atypical moles or malignancies?			Are you pregnant?		
Do you have a pacemaker or defibrillator?			If Yes, date of Last Menstrual Period?		
Have you taken Accutane in the last 6 months?			Are you breast feeding?		
Do you have skin cancer/melanoma?			Are you a smoker?		
Do you have a history of Keloid scarring?			If Yes, how many a day?		
Do you have any abnormal/undiagnosed pigmentation?					

I attest that the above information is true to the best of my knowledge:

Signature:____________________________________ **Date:**__________________

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MEDICAL AESTHETICS