ADVANCED CONCEPTS IN PLASTIC SURGERY

Member
The American Society of Plastic Surgeons
The American Society for Aesthetic Plastic Surgery

Skin Evaluation

Date: _____

- Name: _____ Birth Date: _____
- Have you ever seen a Dermatologist for your skin? Yes No
- Have you previously had:

Chemical peel	Yes	No	Type:	Date:
Laser Resurfacing	Yes	No	Type/Depth:	Date:
Facial Surgery	Yes	No	Procedure:	Date:

- Are you pregnant or lactating? Yes No
- Are you taking Accutane? Yes No Have you ever taken Accutane? Yes No
- What topical medication do you use or have you used: _____ Retin-A _____ Glycolic Acid
  Other: _____
- What oral medications do you use or have you used?
  _____ Tranquilizer _____ Antibiotics _____ Hormones/Birth Control _____ Diuretics

Hypersensitivity & Fragility

Have you ever had a skin allergy? Yes No

To: _____ Cosmetics _____ Fabrics _____ Aspirin
_____ Lidocaine _____ Bacitracin _____ Metals
_____ Other _____

Free Radical Exposure

Do you smoke?	Yes	No	How much? _____
Do you consume alcohol?	Yes	No	How much? _____
Do you have a regular diet?	Yes	No	What type? _____
Do you exercise?	Yes	No	How often? _____
Do you take vitamins?	Yes	No	Multi-Vitamin _____ Other _____

Hormones

Do you have regular periods?	Yes	No
Are you going through menopause?	Yes	No
During pregnancy did you ever get hyperpigmentation or masking?	Yes	No

Pigmentation (Fitzpatrick Scale)

How do you tan? _____ Natural _____ Tanning Bed _____ Topical Tanners

_____ (I) Burn _____ (II) Usually Burn _____ (III) Sometimes Burn
_____ (IV) Rarely Burn _____ (V) Never Burn-"Brown" _____ (IV) Never Burn-"Black"

Pigmentation: _____ Even _____ Uneven _____ Birthmark _____ Pregnancy Mask

(over)

GET IT DONE RIGHT

Vascularity

Broken Capillaries:

_____Cheek Area _____Chin Area _____Forehead _____Entire Face

Acne

Do you have any history of acne or periodic breakout? Yes No

_____ Pimples _____ White Heads _____ Blackheads _____Cysts

_____ Acne Scars _____ Enlarged Pores _____ Flakiness

Facial Wrinkles

_____ Deep Wrinkles _____Crows Feet _____ Fine Lines

Skin Type

(please circle)

Does your skin ever flake or feel tight and dry?	Frequently	Occasionally	Very Rarely
Is your skin ever shiny a few hours after cleansing?	Frequently	Occasionally	Very Rarely
How often do you experience blackheads/blemishes?	Frequently	Occasionally	Very Rarely
How noticeable are your pores?	Very	T-zone	Not Very

Ability to Heal

Does your skin appear fragile or burn easily?	Yes	No
Do you form thick or raised scarring from a cut or burn?	Yes	No
Do you have any health problems?	Yes	No
Do you wax or use depilatories on your face?	Yes	No
Do you ever get cold sores, canker sores, or oral herpes?	Yes	No

Sun History & Lifestyle

Do you work inside or outside?	Inside	Outside
Are your hobbies done mostly inside or outside?	Inside	Outside
In the past (including childhood) did you live in a sun belt area?	Yes	No
In the past have you neglected to use a sunblock when outdoors?	Yes	No

Nationality? (optional) _____

Have you or any member of your family had skin cancer? Yes No

Anatomical Location: _____

How do you want to improve your skin? _____

What specific areas do you want to treat? _____ Face _____ Neck _____ Chest _____ Back

Patient Signature: _____ Date: _____

Technician Signature: _____ Date: _____