



candessa

surgical & laser aesthetics

SKIN EVALUATION

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? (circle all that apply)

- Rosacea
- Excessive Oiliness
- Acne/Pimples
- Freckles
- Clogged Pores
- Upper Lip Lines
- Wrinkles
- Dry Patches
- Scarring
- Brown Spots/Uneven Skin Color
- Hard Bumps Under Skin
- Excess Hair

SKIN CONDITION:

What type of skin do you have? (circle all that apply)

- 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 are you planning to have any facial surgery? Yes No

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

- Laser Hair Removal Chemical Peels Microdermabrasion
 Facial Tinting or Waxing ReFirme Skin Tightening Dermasound Facial
 Facials Lymphatic Drainage Massage Foto-Facials
 Botox Fillers Cosmetic Surgery

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

Last 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

- Psoriasis Dermatitis Fever Blister Rosacea Hepatitis
 Genital Herpes Seizures Melanoma Cancer HIV
 Keloid Scars Other: _____



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SKIN EVALUATION FORM

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:

- | | |
|---|---|
| <input type="checkbox"/> Retin-A (percentage & how long: _____) | <input type="checkbox"/> Zovirax |
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Antibiotics (oral/topical) |

Personal Information:

Circle your current level of stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)

Circle your normal level of stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)

How many ounces of water do you drink daily? _____ Do you take Vitamins? _____

Do you exercise? Yes No If yes, how often? _____

Approx. date of your last sunburn: _____ Do you use tanning beds? Yes No
If yes, how often? _____

Do you smoke? Yes No If yes, how often? _____
Do you live w/ a smoker? Yes No

Are you pregnant? Yes No Are you trying to get pregnant? Yes No

Are you currently breast feeding? Yes No

How did you hear about us? (check all that apply)

- | | | | |
|---|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Website | <input type="checkbox"/> Friend | <input type="checkbox"/> Spa Finder | <input type="checkbox"/> Seen by Dr. |
| <input type="checkbox"/> Referral by Dr. | <input type="checkbox"/> Hometown Values | <input type="checkbox"/> Clipper | <input type="checkbox"/> Value Pages |
| <input type="checkbox"/> Radio: Station _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

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TO BE COMPLETED BY ESTHETICIAN

Professional Product and Treatment Recommendations

Cleanse: _____ Masque: _____

Anti-Age: _____ Eyes: _____

Repair: _____ Tyrosinase Inhibitor: _____

Prevent: _____ Protect: _____

Microdermabrasion SRA ST DSL Dermasound Chem.Peels

Micro-Peel Facials LDM

Sclerotherapy Botox Fillers Other: _____

Notes: _____