PIAZZA CENTER FOR PLASTIC SURGERY AND ADVANCED SKIN CARE

7900 FM 1826, Health Plaza II, Suite 206, Austin, TX 78737
P: 512.288.8200 F: 512.288.8207
www.thepiazzacenter.com

Skin Care Evaluation

Patient Name: Date of Birth

☐ Yes ☐No Are you currently under the care of a physician for your skin?
If yes, please indicate physician name, last seen and results. _____

☐ Yes ☐No Have you previously had a chemical peel?
If yes, type: _____ Date: _____

☐ Yes ☐No Have you previously had Laser Resurfacing, Dermabrasion or Micro Dermabrasion?
If yes, type / depth: _____ Date: _____

☐ Yes ☐No Have you had facial surgery?
If yes, procedure: _____ Date: _____

☐ Yes ☐No Have you done any aggressive exfoliation of your skin in the last 2 weeks?
If yes, please explain: _____

☐ Yes ☐No Are you taking or have you ever taken Accutane?
If currently, what is the dosage and frequency: _____ If in the past, last taken: _____

☐ Yes ☐No Have you or do you use the topical medication Retin-A?
☐ Yes ☐No Have you or do you use the topical medication Hydroquinone?

☐ Yes ☐No Have you ever used a topical fluorouracil preparation on your skin?
If yes, what area of your body: _____Date: _____

☐ Yes ☐No Have you or do you use any other medications for your skin, including topical antibiotics, OTC acne remedies, Hydrocortisone, etc.? If yes, please explain: _____

Please list any oral medications you currently take:
_____
_
(this includes hormones, birth control, antibiotics, tranquilizers, anti-depressants, diuretics, etc)

Please list any nutritional supplements that you take:
_____
_

HYPERSENSITIVITY AND SKIN FRAGILITY

☐ Yes ☐No Have you ever had a skin allergy or sensitivity to ☐cosmetics ☐fabrics ☐other: _____

☐ Yes ☐No Do you have **ANY KNOWN ALLERGIES**? (include any medications, food, etc)
If yes, please list: _____

☐ Yes ☐No Do you "flush" or "appear reddened" easily when you eat spicy food, drink alcohol, or go in the sun?

FREE RADICAL EXPOSURE

☐ Yes ☐No Do you smoke? If yes, how much: _____
☐ Yes ☐No Do you consume alcohol? If yes, how much: _____
☐ Yes ☐No Do you have a healthy diet? List any concerns: _____
☐ Yes ☐No Do you take vitamins? Please list: _____
☐ Yes ☐No Do you exercise? How much: _____

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Patient Name:

For Women Only

☐ Yes ☐No Do you have regular periods?
☐ Yes ☐No Are you or have you gone through menopause?
☐ Yes ☐No Are you pregnant or lactating?
☐ Yes ☐No Are you trying to become pregnant?
☐ Yes ☐No Have you ever been pregnant?
If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask" ☐ Yes ☐No

PIGMENTATION (Fitzpatrick Scale):
How do you tan: ☐I Always Burn ☐II Usually burn ☐III Sometimes burn
☐IV Rarely Burn ☐V Never burn - brown ☐ VI Never burn - black
Pigmentation: ☐ Even ☐ Uneven ☐ Birthmark ☐ Pregnancy Mask

ACNE:
☐ Yes ☐No Do you have any history of acne or periodic breakout?
☐ Pimples ☐ Whiteheads ☐ Blackheads ☐ Enlarged pores
☐ Cysts ☐ Acne scars ☐ Flakiness
☐ Yes ☐No Do you experience breakouts during or around your menstrual cycle?
☐ Yes ☐No Do you **always** have a pimple or some type of breakout?

SKIN TYPE:
Does your skin every flake or feel dry? ☐Frequently ☐Occasionally ☐ Very Rarely
Is your skin ever shiny for a few hours after cleansing? ☐Frequently ☐Occasionally ☐ Very Rarely
How often do you experience blackheads or blemishes ☐Frequently ☐Occasionally ☐ Very Rarely

ABILITY TO HEAL:
Does your skin appear fragile or burn easily? ☐ Yes ☐No If yes, explain: _____
Do you have any problems healing from a cut or burn? ☐ Yes ☐No If yes, explain: _____
Do you have any health problems? ☐ Yes ☐No If yes, explain: _____
Do you ever use depilatories or waxes on your face? ☐ Yes ☐No If yes, last used: _____
Have you ever had a "cold sore"? ☐ Yes ☐No If yes, when was last cold sore: _____

SUN HISTORY & LIFESTYLE:
In the past have you neglected to use a sunscreen when outdoors? ☐ Yes ☐No
Do you ever use tanning beds? ☐ Yes ☐No If yes, how frequent:_____
Do you currently wear a sun protection product all day, every day? ☐ Yes ☐No
Are you willing to wear a sun protection product all day, every day? ☐ Yes ☐No

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? ☐ Yes ☐No
If yes, Who: _____ Location: _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?
1. _____
2. _____
What specific areas do you want to treat ☐Neck ☐ Face ☐ Chest ☐ Back ☐ Other

Patient Signature: _____ Date: _____