The Medical Spa - Medical Skincare Assessment

Today's Date: _____

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Home Phone: _____ Cell Phone: _____

May we text you appointment reminders? (Please Circle) Yes No Carrier: _____

Email Address: _____

May we email you appointment reminders? (Please Circle) Yes No

May we email you marketing information? (Please Circle) Yes No

Personal Medical History

- Have you ever seen a physician or technician specifically for a skin problem or skincare?
  Yes No
  If yes, for what reason: _____
- Are you currently under any other physician's or technician's care for your skin?
  Yes No
  If yes, detail reason(s): _____
- Do you have any health problems? Yes No
  If yes, please list: _____
- Are you currently seeing a physician for any reason? Yes No
  If yes, explain reason: _____
- Do you have any allergies or skin sensitivities: Yes No
  If yes, list all allergies/skin sensitivities: _____
- Do you currently take any oral medications (prescriptive pharmaceuticals)? (include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc.)
  If yes, list all oral medications: _____
- Do you use any topical medications (prescriptive pharmaceuticals)? (include Retin-A, Hydroquinone, Accutane, Benzoyl Peroxide, Antibiotics, Metrogel, Efudex, Cortisone, etc.)
  If yes, list all topical medications: _____

- Have you ever taken Accutane? Yes No
  I currently take Accutane: Dosage Prescribed: _____ Frequency Taken: _____
  I took Accutane in the past: Date Discontinued: _____ Dosage Used: _____
- Have you ever had a "cold sore"? Yes No If yes, when was your last cold sore? _____
- Do you wear contact lenses? Yes No
- Do you ever use depilatories or waxes on your face? Yes No
  If yes, when last used? _____
- Do you smoke? Yes No If yes, how much/often? _____
- Do you consume alcohol? Yes No If yes, frequency/amount: _____
- Do you exercise? Yes No If yes, how often? _____
- Do you take vitamins? Yes No If yes, what type(s)? _____
- Do you drink water? Yes No If yes, how many glasses per day? _____
- Do you consume caffeine? Yes No If yes, how much per day? _____
- Have you ever had keloid scarring? Yes No
- Have you ever had hypertrophic scarring? Yes No
- Do you have difficulty healing from a cut or a burn? Yes No

For women only:

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

Skin Procedure and Product History

Have you ever had any of these skin procedures (treatments)?

Microdermabrasion	Yes	No	Date of last procedure: _____
Chemical Peel(s)	Yes	No	Date of last procedure: _____
Intense Pulsed Light	Yes	No	Date of last procedure: _____
Laser Resurfacing	Yes	No	Date of last procedure: _____
Dermabrasion	Yes	No	Date of last procedure: _____
Other: _____	Yes	No	Date of last procedure: _____

What type of skin do you have? (Please Circle)

Oily Skin Dry Skin Combination Acne/Breakout Sensitive Normal

What skincare products do you use as a daily regimen? (Please Circle)

Soap Cleanser Toner Masque Scrub/Peel Moisturizer Sunscreen Other: _____

What brand of skin care products do you use? _____

What temperature water do you use to cleanse with? (Please Circle) Cool Warm Hot

Have you had any reaction to any of the following? (Please Circle)

Cosmetics Medicine Aspirin Fragrance Sunscreen Pollen Iodine
AHAs Retinoid Animals Food: _____ Other: _____

If yes, please explain: _____

Have you ever been diagnosed with rosacea? Yes No

Do you ever use tanning beds? Yes No If yes, when? _____

How does your skin react to sun exposure? / How do you tan? (Please Circle)

I - Burn II - Usually Burn III - Sometime Burn

IV - Rarely Burn V - Never Burn / Always Tan VI - Never Burn

How to you want to improve your skin?

1. _____
2. _____

What specific skin areas do you want to treat? (Please Circle)

Face Neck Chest Back Other: _____

Consent to Communicate:

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

Preferred Contact Method: (Please Circle) Home Cell

Call Cell Phone Yes No Ok to Leave VM? Yes No

Ok to Leave Msg w/ Another Person? Yes No

Call Home Phone Yes No Ok to Leave VM? Yes No

Ok to Leave Msg w/ Another Person? Yes No

Send Regular Mail to Home Address? Yes No

Notice to Dispense:

Maryland laws allows us to dispense prescription products to you if it is more convenient than going to a pharmacy. The determination of "convenience" is made entirely by you. We will be happy to write a prescription for you. Note that Obagi, ZO Obagi SkinHealth, Skinbetter Science, Topix Pharmaceuticals, Silagen and Latisse are not available through pharmacies and are only distributed through health care providers.

By consenting below, I am aware that I am purchasing prescription products today from Dr. Brent Birely at Artistry in Plastic Surgery because it is more convenient to me than finding these products elsewhere.

Review of Patient Information Authorization

I have read the Medical Skincare Assessment and disclosed my medical history to the best of my knowledge.

Patient Signature: _____

Date: _____

Signature of Physician or Physician Representative: _____

Date: _____