SENARA

MEDICAL SKIN CARE PROFILE

HOW DID YOU HEAR ABOUT US? _____

FIRST NAME _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE

HOME PHONE _____ MOBILE PHONE _____

EMAIL ADDRESS _____

BIRTHDAY _____ TODAY'S DATE _____

PERSONAL HISTORY

Are you currently seeing a physician for **any reason.** If yes, explain reason: □ Yes □ No

_____

Have you ever seen a physician or technician specifically for a skin problem or skincare? □ Yes □ No
If yes, when and 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)

_____

Have you or any family member ever had a skin lesion removed by a physician? □ Yes □ No
If yes, who had lesion removed? _____
Anatomical location of lesion? _____
Do you have any health problems? If yes, please list □ Yes □ No

_____

Do you wear contact lenses? □ Yes □ No
Do you have **any** allergies or skin sensitivities? If yes, list **all** allergies/skin sensitivities □ Yes □ No

_____

Do you currently take **any** oral medications (prescriptive pharmaceuticals)? (include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.) □ Yes □ No
If yes, list all **oral** medications:

_____

Do you use any topical medications (prescriptive pharmaceuticals)? (includes Retin-A®, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.) □ Yes □ No
If yes, list all **topical** medications:

_____

Have you ever taken an oral retinoid? □ Yes □ No
I currently take an oral retinoid: Date discontinued_____ Dosage/frequency _____
I took an oral retinoid in the past: Date discontinued_____ Dosage/frequency _____
Have you **ever** had a "COLD SORE"? □ Yes □ No
If yes, when was your last cold sore?_____
Do you ever use depilatories or waxes on your face? □ Yes □ No
If yes, when last used?_____

SKINCEUTICALS

Do you smoke? □ Yes □ No If yes, how much/often? _____
Do you consume alcohol? □ Yes □ No If yes, frequency/amount_____
Do you have a healthy diet? □ Yes □ No List any dietary concerns_____
Do you exercise? □ Yes □ No If yes, how often?_____ Type(s)_____
Do you take vitamins? □ Yes □ No If yes, what type(s)? _____
Do you drink water? □ Yes □ No If yes, how many glasses per day?_____

For Women Only: □ Yes □ No
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 ever experience hyperpigmentation or a "pregnancy mask"? □ Yes □ No

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? If yes, list products used: □ Yes □ No

_____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? If yes, explain type(s) of exfoliation: □ Yes □ No

_____

SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? If no, skip this section. □ Yes □ No

Microdermabrasion □ Yes □ No Date of last procedure _____
Chemical Peel(s) □ Yes □ No Type of procedure(s)/date _____
Phototherapy □ Yes □ No Type of procedure(s)/date _____
Laser Resurfacing □ Yes □ No Type of procedure(s)/date _____
Radiofrequency □ Yes □ No Type of procedure(s)/date _____
Dermabrasion □ Yes □ No Type of procedure(s)/date _____
Facial Surgery □ Yes □ No Type of surgery(s)/date _____
Other procedures/date? □ Yes □ No Type of procedure(s)/date _____
Additional comments about above procedure(s) _____

OILY SKIN OR ACNE

Any acne breakout? □ Blackheads □ Whiteheads □ Enlarged Pores □ Pustles □ Large Pores □ Cysts
Do you have any history of acne or periodic breakout? □ Yes □ No If yes: □ Now □ In past?
Women: Do you only experience breakout during or around your menstrual cycle? □ Yes □ No
Do you always have a pimple or some type of breakout? □ Yes □ No
Does your skin ever flake or feel tight and dry? □ Frequently? □ Occasionally? □ Rarely?
Is your skin ever shiny (oily) a few hours after cleansing? □ Frequently? □ Occasionally? □ Rarely?
How noticeable are your pores? □ Very? □ T-zone only? □ Not very noticeable?

SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or reddened" when eating spicy food, drink alcohol, angry, go in the sun, etc.? □ Yes □ No
Does your skin ever get flaky or itch? □ Yes □ No If yes, is it □ Season? □ All the time?
Have you ever been diagnosed with Rosacea? □ Yes □ No If yes, date of diagnosis? _____
Do you have difficulty healing from a cut or burn? □ Yes □ No If yes, explain _____
Have you ever had keloid scarring? □ Yes □ No If yes, explain _____

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? □ Deep wrinkles □ Crow's feet □ Fine lines □ Skin Laxity

Have you been treated with: □ Botox? □ Fillers? If yes, date of last treatment_____

Do you work inside? □ Yes □ No Occupation _____

Are your hobbies done mostly outside? □ Yes □ No Hobbies _____

In the past (including childhood) did you live in a sun belt? □ Yes □ No If yes, where? _____

In the past have you neglected to use a sunscreen when outdoors? □ Yes □ No

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

Are you willing to wear a sun protection product all day, every day? □ Yes □ No

BASIC SKIN PROFILE

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?

□ I Burn □ II Usually Burn □ III Sometimes Burn

□ IV Rarely Burn □ V Never Burn-"Brown" □ VI Never Burn-"Black"

Is your skin pigmentation (skin discoloration): □ Even □ Uneven □ Birthmark(s) □ Pregnancy Mask

What is your Ethnicity and Race (heritage)? _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1._____

2._____

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

□ Face □ Neck □ Chest □ Back □ Other _____

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date: