

Skin Assessment Form



1700 Hospital Dr. | Santa Fe, NM 87501 | 505 988 2121 | bonitamedical.com

Name _____ Age _____ Date of Birth _____

Address/City/State _____ Zip _____

E-mail _____ Social Security # _____

Home Phone _____ Work Phone _____ Other _____

Last visit with a dermatologist:

Reason: _____

Have you previously had a Chemical Peel? Y N

Type of Peel: _____ Date: _____

Resurfacing/Dermabrasion/Microdermabrasion? Y N

Type/Depth: _____ Date: _____

Facial Surgery? Y N

Procedure: _____ Date: _____

Have you done any aggressive exfoliation in the last two weeks? Y N

If yes, explain: _____

Are you taking Accutane? Y N If yes, what dosage/how often?

Have you taken Accutane in the past? Y N If yes, when?

Check the topical medications you use or have used in the past:

Retin A Hydroquinone Hydrocortisone Topical Antibiotics
 Other _____ On what area of the body? _____

Please list any oral medications you currently take, including all hormones, birth control pills, antidepressants, tranquilizers, antibiotics and diuretics:

Please list nutritional supplements you are currently taking:

What skin care products do you use frequently?

Hypersensitivity & Skin Fragility

Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives etc.) Y N

If yes, explain:

Do you have any known allergies to anything? Y N

If yes, please list (that includes medications, aspirin and foods):

Do you flush easily or appear reddened when you eat spicy food, use certain detergents, drink alcohol, go in the sun, etc.? Y N

Free Radical Exposure

Do you smoke? Y N How Much? _____
Do you consume alcohol? Y N How Much? _____
Do you have a healthy diet? Y N
Do you exercise? Y N If Yes, How Often? _____

Female

Do you have regular periods? Y N
Are you going through menopause? Y N
Are you pregnant? Y N
Are you lactating? Y N
Did you experience hyper-pigmentation or a “pregnancy mask”? Y N

Pigmentation Even Uneven Birthmark

How do you tan?

Burn Usually Burn Sometimes Burn Rarely Burn Never Burn “Brown” Never Burn “Black”

Broken Capillaries:

Nose Cheeks Chin Forehead Entire Face

Acne:

Periodic Breakouts Pimples White Heads Black Heads Cysts
 Acne Scars Flakiness Cold Sores Enlarged Pores
 Always a pimple or a some type of breakout Breakout only during menstrual cycle

Facial Wrinkles:

Deep Wrinkles Crows Feet Fine Lines

Have you been treated with Botox? Y N **Collagen?** Y N If Yes, Date of Last Treatment _____

Skin Type

- Does your skin appear fragile or burn easily?** Rarely Occasionally Frequently
- Do you have problems healing from a cut or burn?** Rarely Occasionally Frequently
- Do you have health problems?** Rarely Occasionally Frequently
- Do you ever use depilatories/waxes on your face?** Rarely Occasionally Frequently
- Have you ever had a cold sore?** Rarely Occasionally Frequently
- How noticeable are your pores?** Very T-Zone Not Very

Sun History

- Do you work inside?** Y N Occupation _____
- Are your hobbies done mostly outside?** Y N Hobbies _____
- Have you ever lived in the sun belt?** Y N Where? _____
- Do you use tanning beds?** Y N If Yes, When? _____
- Do you currently wear sun protection?** Y N If Yes, Everyday? Y N
- Are you willing to wear a sun protection everyday?** Y N

Have you or any member of your family had skin cancer? Y N
If Yes, Where was the skin cancer located?

Are you currently seeing a physician for any reason? Y N
If yes, explain:

What specific areas would you like to treat?
 Face Neck Chest Arms Hands Back Other _____

How do you want to improve your skin?

Patient Signature _____ Date _____

Technician Signature _____ Date _____

M.D. Signature _____ Date _____