Confidential Skin Care Evaluation

This is an electronic form (e-Form). An e-form can be filled out without printing. We ask that you answer the following questions so we may have a better understanding of your general health and life style. To be well prepared for your consultation, please email to: info@globalskin-solutions.com

Date of Birth: _____ Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Receive our Newsletter: ☐Yes ☐No

Emergency Contact Name _____ Phone: _____ Relationship: _____

1. What is the reason for your visit? _____

2. What special areas of concern do you have? _____

3. Please check all that applies

☐ Acne scarring	☐ Pigmentation	☐Age spots
☐ Acne	☐Sun damage	☐Fine Lines and wrinkles
☐Scars or Keloids	☐Stretch Marks	☐Ingrown Hairs

4. Have you ever had

☐Microdermabrasion	☐LED	☐Enzyme treatments
☐Cosmetic surgery	☐Laser Hair Removal	☐Body treatments
☐Cosmetic fillers	☐Electrolysis in the past 14 days	☐Chemical peels Percentage?
☐Botox®?	☐Dermatitis	☐Home care with acids
☐Restylane®	☐Keloid scarring	☐Permanent Cosmetics
☐Collagen Injections	☐At home microdermabrasion	

Comments: _____

5. Have you seen a Dermatologist in the past Year? ☐Yes ☐No

Name of dermatologist _____ Reason for visit _____

6. Are you presently under the care of a physician? ☐Yes ☐No If yes, explain _____

ALLERGIES/REACTIONS

7. Do you have or ever had a reaction/allergy to

☐Metals	☐Chemical or natural peels?	☐Food
☐Fragrance	☐Cosmetics	☐Airborne particles
☐Aspirin or Salicylates	☐Ingredients in cosmetics.	☐Herbs or flowers

FOR MEN

8. Do you experience breakouts? ☐Yes ☐No

9. Do you have ingrown hair? ☐Yes ☐No

FOR WOMEN

Are you on birth control? ☐Yes ☐No Are you pregnant? ☐Yes ☐No

Do you take hormone replacement? ☐Yes ☐No

SUN PROTECTION

10. Do you use a sunscreen/sun block? ☐Yes ☐No ☐ SPF 15 ☐ SPF 30 ☐Other(please explain) _____
11. Amount of sun exposure? Week _____hrs Weekend _____hrs
12. Do you sunbathe or participate in outdoor activities? ☐Yes ☐No
13. If yes, what outdoor activities? _____
14. Do you use tanning booths? ☐Yes ☐No
15. Have you tanned in a tanning booth in the last 14 days? ☐Yes ☐No
16. Have you had direct sun exposure in the last 10 days? ☐Yes ☐No

LIFESTYLE

17. Do you normally sleep well? ☐Yes ☐No Number of hours _____
18. Do you wear contact lenses? ☐Yes ☐No
19. Do you smoke? ☐Yes ☐No How many per day _____
20. Consume alcohol? ☐Yes ☐No How much per week _____
21. Do you regularly exercise? ☐Yes ☐No If yes, is it strenuous? ☐Yes ☐No
22. Do you play sports? ☐Yes ☐No If yes, do you wear a ☐Cap ☐Helmet ☐Headband? ☐Other?
23. Do you have food intolerances?. ☐Yes ☐No
    If yes, explain _____
24. Do you follow any special diet? ☐Yes ☐No If yes, explain _____
25. Daily water intake: _____ glasses a day.
26. How many cups of caffeine-type beverages (coffee, tea, soft drinks) do you consume daily? ☐None ☐1-3 cups ☐4 or more
27. What do you consume on a daily basis? ☐Fruit ☐Protein ☐Complex Carbohydrates ☐Vegetables & Salad
28. Do you take vitamins? ☐Yes ☐No If yes, what _____
29. Number of work hours. _____ Day Shift _____ Night Shift _____ Stay at home How many take-out meals/week _____
30. Student ☐ School _____
31. What is your stress level? ☐High ☐Medium ☐Low
32. Do you drink milk? How much ☐Daily ☐Weekly ☐Once in a while
33. Do you eat cheese? How much? ☐Daily ☐Weekly ☐Once in a while

SKIN CARE ROUTINE

34. Have you had facial treatments in the past? ☐Yes ☐No
35. Have you had extractions in the past two weeks? ☐Yes ☐No
36. What is your daily face routine?

    Cleanser: ☐ How does your skin feel after use? _____ **Toner** ☐ How does you skin feel after use? _____

    ☐**Day Cream/Moisturizer** for: ☐Dry Skin ☐Oily/Acne Skin ☐Sensitive Skin

    ☐**Mask:** How many times a week? _____ ☐**Night Cream** ☐**Eye Cream/Serum/Mask**

YOUR FEATURES

37. Eye Color (check one): ☐Blue ☐Green ☐Hazel ☐Gray ☐Light Brown ☐Dark Brown
38. Natural Hair Color (check one): ☐Blonde ☐Red ☐Light Brown ☐ Medium Brown ☐Dark Brown ☐Black ☐Gray/Silver

☐ Always burns, never tan ☐Burns moderately, tan gradually ☐Rarely burns, deep tan
☐ Burns easily, tan slightly ☐Seldom burns, always tan ☐Never burns, deeply pigmented

39. How would you describe your skin? (Check all that applies):

☐Normal	☐Oily	☐T-Zone	☐Dry	☐Wrinkled	☐Cystic
☐Sun-Damaged	☐Uneven tones	☐Blotchy	☐Mature	☐Scarred	☐Sallow
☐Acne	☐Milia	☐Comedones	☐Occasional breakouts	☐Saggy	☐Large pores
☐Florid	☐Rosacea	☐Congested		☐Firm	☐Small Pores
☐Hypopigmented (Light spots)	☐Hyperpigmented (Discoloration)	☐Post-Inflammatory hyperpigmentation (Dark spots)	☐Freckled	☐Perfumed Stained	☐Melasma (Dark patches)

GENETIC BACKGROUND – Does your genetic background include any of the following (check all that applies).

40. ☐ Asian ☐Asian Subgroup ☐Pacific Islander ☐Italian/Mediterranean ☐Latino/Hispanic ☐ African ☐African-American ☐Native American ☐Middle Eastern ☐Spanish ☐European ☐Don't Know

GENERAL HEALTH

41. How would you describe your overall health? ☐Excellent ☐Good ☐Poor Explain: _____

42. Have you had any of the following, past or present?

Acne	☐Yes	☐No	Diarrhea/constipation	☐Yes	☐No	Hormone Imbalance	☐Yes	☐No
If yes, when? Teens☐ Adult☐			Eczema	☐Yes	☐No	Infections	☐Yes	☐No
Allergies	☐Yes	☐No	If yes, to what? _____			Lupus	☐Yes	☐No
Arthritis or Bursitis	☐Yes	☐No	Epilepsy	☐Yes	☐No	Metal Implants	☐Yes	☐No
Blood Pressure	☐Yes	☐No	Hay Fever	☐Yes	☐No	Pace Maker	☐Yes	☐No
Breast Implant	☐Yes	☐No	Headaches	☐Yes	☐No	Phlebitis	☐Yes	☐No
Cancer	☐Yes	☐No	If yes, how often _____			Psoriasis	☐Yes	☐No
If yes, what type _____						Serious Injury	☐Yes	☐No
Cataracts	☐Yes	☐No	Heart Condition	☐Yes	☐No	If yes, what _____		
Cholesterol	☐Yes	☐Normal	If yes, how long? _____					
Claustrophobic	☐Yes	☐No	Hepatitis	☐Yes	☐No	Vitiligo	☐Yes	☐No
Circulatory	☐Yes	☐No	Hirsutism	☐Yes	☐No	Thyroid	☐Yes	☐No
Diabetes	☐Yes	☐No	HIV	☐Yes	☐No	Varicose Veins	☐Yes	☐No

NOTE: *Diabetes and epilepsy requires written permission from a physician.*

MEDICATIONS and/or Over-the-counter products (Check all that applies):

43. Do you presently use or used in the past any of the following:

☐Benzoyl Peroxide	☐Salicylic Acid	☐Hydrocortisone	☐Tazarotene (Tazorac)
☐Glycolic Acid	☐Sulfur	☐Hydroquinone	☐Isotretinoin (Accutane)
☐Lactic Acid	☐Vitamin A	☐Tretinoin (Retin-A/Renova)	☐Micro, Renova or Avita)
☐Resorcinol	☐Vitamin C	☐Azelaic Acid (Azelex, Finacea)	☐Adepalene (Differen)
			☐Other _____

COMMITMENT

44. How committed are you to achieving results? ☐Not sure ☐Somewhat committed ☐Very committed

45. If committed and depending upon the skin condition, we may recommend a 4 to 12 week corrective program. This will include professional weekly or bi-weekly treatments and home care products to assure the success of the outcome. ☐Yes, I'm committed ☐No not interested

46. Any special requests or concerns?

By checking the box and printing my name I acknowledge that all the questions above have been answered to the best of my knowledge: ☐

Name: _____ Date: _____