

BODY GARAGE SKIN CARE HISTORY FORM



Patient _____ Date _____

Skin Disease History: (Please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Rosacea
Asthma	Hay Fever/Allergies	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	Other _____
Blistering Sunburns	Poison Ivy	_____
Dry Skin	Precancerous Moles	

Do you have a family history of Melanoma? YES NO If yes, which relative? _____

Do you have a history of Keloid Scarring (thick or raised scars from cuts or burns)? YES NO

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? YES NO If yes, please describe: _____

What topical medications or creams are you currently using? Retin-A Taxorac Renova Avita Other _____

Are you currently taking or have you taken Accutane in the past 9 months? YES NO

Skin Care History: (If yes, please note when)

Self Tanner	YES NO	_____
Tanned Skin	YES NO	_____
Waxing	YES NO	_____
Tweezing	YES NO	_____
Previous Laser Treatment	YES NO	_____
Permanent lip/brow tattoo	YES NO	_____
Cosmetic Fillers	YES NO	_____
Chemical Peels	YES NO	_____
Microdermabrasion	YES NO	_____
Facials	YES NO	_____

Have you had any previous cosmetic procedures other than listed above? YES NO

If yes, please list: _____

Social History:

Do you exercise? YES NO How often? _____

Do you eat a healthy diet? YES NO How often? _____

Do you consume alcohol? YES NO How often? _____

Level of outdoor activity: (Occupation, sports, boating, beach) High _____ Medium _____ Low _____

Do you currently have a sun burn? YES NO

Do you use a sunscreen? YES NO If yes, what SPF? _____ Do you tan in a tanning salon? YES NO

Please circle which skin type (I to VI) describes you best:

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
I	White; very fair; red or blond hair; blue eyes; freckles	Always burns, never tans
II	White; fair; red or blond hair; blue, hazel, or green eyes	Usually burns, tans with difficulty
III	Cream white; fair with any eye or hair color; very common	Sometimes mild burn, gradually tans
IV	Brown; typical Mediterranean Caucasian skin	Rarely burns, tans with ease
V	Dark Brown; mid-eastern skin types	Very rarely burns, tans very easily
VI	Black	Never burns, tans very easily

Skin Concerns:

What are you looking to improve? List your top 3 cosmetic concerns:

1. _____
2. _____
3. _____

Is there any particular treatment(s) you would like to discuss today? _____

What skin care line are you currently using? _____

Please circle all that apply: Cleanser Toner Moisturizer with sunscreen Eye Cream Night Repair Cream Mask

Would you like to discuss skin care products? YES NO

IPL-Permanent Hair Reduction: (IPL Patients only)

What color is the hair at the treatment site: Black Brown White Grey Red Other _____

What are you currently using/doing to remove hair growth at the treatment site? _____

Any known medical conditions causing increased risk of hair growth? (Hormonal abnormalities, Polycystic Ovary Disease, etc.)? YES NO If yes, please explain: _____

History of abnormal lab studies to check hormonal levels? YES NO

Are you under the care of a Physician? YES NO If yes, please explain: _____

Photosensitive Disorders? (ie., lupus, sun rash, hives, etc.) YES NO

Problems with Circulatory System? (ie., Collagen Disease, Raynaud's , Chilblains, etc.) YES NO

Previous Laser Treatment? YES NO Previous electrolysis? YES NO

Are you currently intentionally tanning? (tanning beds, laying out, etc.) YES NO

Do you wear a broad spectrum sun block every day? YES NO

I, _____, ATTEST TO THE ABOVE TO BE TRUE AND ACCURATE. I UNDERSTAND THAT MY
TECHNICIAN RELIES UPON THIS INFORMATION TO PROVIDE A SAFE AND EFFECTIVE TREATMENT.

PATIENT SIGNATURE: _____

FOR STAFF USE ONLY:

Reviewed by: _____ Date _____

