Caudle Cosmetic Surgery, Wellness, & Medical Spa 189 Corporate Drive #10 Johnson City, TN 37604 (423) 926-2400

Medical Skincare Assessment

Date: _____/_____/_____

First Name: _____Middle: _____Last Name: _____

Address: _____ City: _____State:_____Zip_____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____

Best time to contact me is:_____ ☐ morning ☐ afternoon ☐ evening **at** ☐ Home ☐ Work ☐ Cell.

If you provide permission to the following, we can send you appointment reminders and special events and discounts:

☐ Okay to leave voicemail? ☐ Okay to send Text? ☐ Okay to send email? ☐ Sign me up for Specials?

Emergency contacts or Guardian's Name:_____ Phone (____)_____

Provide **email** & you can access your health records online securely:_____

How did you hear about us? ☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Instagram ☐ Twitter

☐ Billboard ☐ Radio ☐ TV ☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Other _____

To the Patient: Your results and safety depend upon a full & complete history

FACIAL TRIAD of AGING

1. AGING of SKIN (thinning of skin, solar changes, wrinkling, all worse with smoking and sun exposure)
2. LOSS of FACIAL VOLUME (primarily fat & bone)
3. LAXITY of Soft Tissue: (Primarily influenced by soft tissue volume loss and the effects of gravity)

Patient Concerns / Desires

FACE / NECK: □ Look younger □ Jowling □ Loose Skin □ Skin tone (Solar changes) □ Wrinkles / Lines
□ Textural changes face □ Eye bags □ Eye lids □ Dark circles under eyes □ Thin lips
□ Nasolabial folds □ Sad mouth □ Gummy smile □ Cheekbone Loss □ Sunken temples

Other: _____

Your Expectations: _____

PERSONAL HISTORY

- Yes No Do you wear contact lenses?
- Yes No Have you ever seen a physician or technician specifically for a skin problem or skincare?
  If yes, when and for what reason?_____
- Yes No Are you currently under any other **Physician's** or **Provider's** care for your skin? If yes, detail reason(s) _____
  _____
- Yes No History of keloids or hypertrophic scars?
- Any **SKIN ALLERGIES or SENSITIVITES**? List all:_____
  _____
- Any **TOPICAL SKIN MEDICATIONS** (prescriptive pharmaceuticals)? (Includes Retin-A, Hydroquinone, Accutane, Benzoyl Peroxide, Antibiotics, MetroGel, Efudex, Cortisone, etc.). List ALL topical medications _____
  _____
- Have you ever taken **Accutane (isotretinoin)**? ☐ No If yes how long and last dose? _____
- Yes No Have you ever had a "COLD SORE"? When was your last cold sore? _____
- Yes No Ever use depilatories or waxes on your face? If yes, when last used?_____

Do you have a healthy diet?	**Yes**	**No**	List any dietary concerns_____
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?_____

SKIN PROCEDURE HISTORY

Please indicate if and when you have had any of the following procedures:

Microdermabrasion	**Yes**	**No**	Date of last procedure_____
Chemical Peels	**Yes**	**No**	Type of peel(s)/date(s)_____
LED/Phototherapy	**Yes**	**No**	Type of procedure(s)/date(s)_____
Laser Resurfacing	**Yes**	**No**	Type of procedure(s)/date(s)_____
Radiofrequency	**Yes**	**No**	Type of procedure(s)/date(s)_____
Dermabrasion	**Yes**	**No**	Type of procedure(s)/date(s)_____
Facial Surgery	**Yes**	**No**	Type of procedure(s)/date(s)_____
Other Laser/IPL Procedure	**Yes**	**No**	Type of procedure(s)/date(s)_____
Skin Pen / Microneedling	**Yes**	**No**	Date(s) _____

Other procedures/dates/Comments?_____

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SKIN PRODUCT HISTORY

Yes No Do you currently use any skincare products as a regular regimen? If yes, list products used: _____

_____

Yes No Have you done any exfoliation to your skin in the last 4 weeks? If yes, explain type(s) of exfoliation: _____

_____

For Women Only: **GYN:** # of Pregnancies _____, # of Births _____, # of miscarriages/abortions _____. Age at menopause _____.

__ Painful intercourse Last menstrual period ___/___/_____. __Irregular, __light, __ medium __heavy menstrual period

Are you trying to become pregnant **Yes** **No** Are you pregnant or lactating? **Yes** **No**

If yes, during pregnancy did you ever experience hyperpigmentation or pregnancy mask? **Yes** **No**

LIST ANY MEDICAL PROBLEMS: (Including but not limited to Diabetes, Auto-Immune Disorder, HIV, Hepatitis, Thyroid Imbalance, Cancer, Blood Clotting or Bleeding Disorder, Seizure Disorder, Other). _____

_____

LIST ALL MEDICATIONS: (include ALL prescriptive pharmaceuticals or over the counter such as: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc _____

_____

LIST ALL SURGERIES: ☐ No prior surgery. (Including but not limited to any Cosmetic surgery, Facial surgery, Neck surgery, etc) _____

_____

Check those below that apply to you

☐ **Any History of 'Panic' or 'Anxiety' attacks?** Last attack? _____

☐ **Any history of Staph or MRSA infections?** Last episode? _____

☐ **Latex Allergy:** Explain: _____

☐ **Xylocaine "caine" or any local anesthetic Allergy?** Explain: _____

List ALL DRUG ALLERGIES: _____

List Environmental Seasonal Allergies: _____

☐ Are you presently on any **steroids** or medications containing steroids? Explain: _____

☐ Any **Alcohol use:** How much & how long? _____

☐ Any **Tobacco use:** (check) __ Smoke: __ Dip ___ Chew ___ eCig ___ Cigars. ___ Marijuana. If you quit, when? _____

How much & how long? _____

History of Substance / Drug Abuse or Alcohol Abuse? Yes No Explain: _____

OILY SKIN OR ACNE

☐ History of acne or periodic breakouts? Check if applies: ___Now? __Recent? ____Distal Past?

Blackheads **Whiteheads** **Enlarged pores** **Pustules** **Cysts**

☐ Do you only experience breakout during or around you menstrual cycle?

☐ Do you ALWAYS have a pimple or some type of breakout? **Frequently** **Occasionally** **Very Rarely**

☐ Is your skin ever shiny (oily) a few hours after cleansing? **Frequently** **Occasionally** **Very Rarely**

SKIN PORES ☐ Do you have large or noticeable skin pores?

SENSITIVE AND INTOLERANT OR DRY SKIN

☐ Flaky skin, itchy skin, or feel tight and dry? **Frequently** **Occasionally** **Very Rarely**

☐ Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc?

☐ Diagnosed with **Rosacea**? When: _____

☐ Diagnosed with **Melasma**? When: _____

☐ Do you have difficulty healing from a cut or burn? If yes, explain: _____

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

☐ Have you been treated with **Botox?** Date(s) of last treatment _____

☐ Have you been treated with **Fillers?** Date(s) of last treatment _____

Do you work ☐ Inside? ☐ Outside? Occupation: _____ ☐ Hobbies done mostly outside? Hobbies: _____

☐ In the past (including childhood) did you live in a sun belt? If yes, where? _____

In the past have you ☐ neglected to use sunscreen when outdoors. ☐ Used tanning beds? When & how often? _____

Do you currently wear a sun protection product? ☐ all day, ☐ every day? Willing to wear a sun protection? ☐ all day, ☐ every day?

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

_____

Patient Signature: _____ Date: _____/_____/_____

Fitzpatrick Skin Type Scale _____ Glogau Aging Type Scale _____

Recommendations: _____

_____

_____

_____ ____/____/_____

MD/NP/Esthetician Signature **DATE**