The Skin Rejuvenation Center

at Richmond Surgical Arts, Inc.

Gregory T. Lynam, M.D., D.D.S.

PATIENT'S NAME:_____ **Date:**____/____/____

SKIN EVALUATION

Have you seen a dermatologist for your skin? ☐YES ☐NO

What was the reason for that visit?_____

_____

Have you ever used Accutane? ☐YES ☐NO

Which of the following topical medications have you used? Please check all that apply.

☐ACNE ☐RETIN-A ☐GYLCOLIC ACID ☐OTHER_____

Which of the following oral medications have you used or do you currently use? Please check all that apply.

☐Tranquilizer ☐Antibiotics ☐Hormones or Birth Control ☐Diuretics

HYPERSENSITIVITY AND FRAGILITY

Have you ever had a skin allergy? ☐YES ☐NO

☐Cosmetic ☐Fabrics ☐Aspirin ☐Rashes ☐Other:_____

FREE RADICAL EXPOSURE

Do you smoke? ☐YES ☐NO How much?_____

Do you consume alcohol? ☐YES ☐NO How much?_____

Do you have a regular diet? ☐YES ☐NO

Do you exercise? ☐YES ☐NO How much?_____

Do you take vitamins? ☐YES ☐NO

☐Multi-vitamin ☐Antioxidant ☐Other:_____

HORMONES

Do you have regular periods? ☐YES ☐NO

Are you going through menopause? ☐YES ☐NO

During pregnancy, did you ever get hyperpigmentation or masking? ☐YES ☐NO

PIGMENTATION

How often do you tan? ☐Always burn ☐Usually burn ☐Burn then tan ☐Usually tan ☐Always tan

How would you describe your pigmentation? ☐Even ☐Uneven ☐Birthmark ☐Pregnancy mark

VASCULARITY

Broken capillaries? ☐Nose ☐Cheek ☐Chin area ☐Forehead ☐Entire face

ACNE

Do you have any history of acne or periodic breakouts?

☐Pimples ☐Whiteheads ☐Blackheads ☐Enlarged pores ☐Flakiness ☐Acne scars

FACIAL WRINKLES ☐Deep wrinkles ☐Crows feet ☐Fine lines

SKIN TYPE

Does your skin ever flake or feel tight and dry? ☐Frequently ☐Occasionally ☐Very rarely

Is your skin ever shiny a few hours after cleaning? ☐Frequently ☐Occasionally ☐Very rarely

How often do you experience blackheads or facial blemishes? ☐Frequently ☐Occasionally ☐Very rarely

How noticeable are your pores? ☐Very ☐T-zone ☐Not very

ABILITY TO HEAL

Does your skin appear fragile, burns easily? ☐YES ☐NO

Do you form thick or raised scarring from a cut or burn? ☐YES ☐NO

Do you have any health problems? ☐YES ☐NO

Do you wax or use depilatories on your face? ☐YES ☐NO

Do you ever get cold sores? ☐YES ☐NO

SUN HISTORY AND LIFESTYLES

What percentage of time do you spend in the sun? Summer_____ Winter_____

In the past [including childhood], did you live in a sunbelt and sunbathe? ☐YES ☐NO

[Need for enhanced exfoliation or Retin-A]

In the past, have you neglected to use a sun block when outdoors? ☐YES ☐NO

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? ☐YES ☐NO Anatomical location:_____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

WHAT SPECIFIC AREAS TO YOU WANT TO TREAT?

☐Face ☐Neck ☐Chest ☐Back ☐Hands ☐Forearms ☐Lower legs ☐Other:_____

Technician's Signature:_____ Date:____/____/____