the heart shop

223 E. Union St. *Upstairs*
Downtown Prescott, AZ 86303
(928)-776-7546
(928)-237-4239 FAX

Douglas W. Rothrock, M.D. – Medical Director

MEDICAL SKINCARE ASSESSMENT

SKINCARE HISTORY

Do you use any topical medications (prescriptive pharmaceuticals)?
(includes Retin-A®, Hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)
If yes, list all topical medications_____

Have you ever taken Accutane®? Yes No

I currently take Accutane: Dosage prescribed_____ Frequency taken_____

I took Accutane in the past: Date discontinued_____ Dosage/frequency used_____

Have you ever had a "COLD SORE"? Yes No If yes, when was your last cold sore?_____

Do you ever use depilatories or waxes on your face? Yes No If yes, when last used?_____

SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? Yes No

If yes, list products used_____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? Yes No

If yes, explain type(s) of exfoliation_____

SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? Yes No If no, skip this section.

Microdermabrasion Yes No Date of last procedure _____

Chemical Peels Yes No Type of procedure(s)/date_____

Phototherapy Yes No Type of procedure(s)/date_____

Laser Resurfacing Yes No Type of procedure(s)/date_____

Radiofrequency Yes No Type of procedure(s)/date_____

Dermabrasion Yes No Type of procedure(s)/date_____

Facial Surgery Yes No Type of surgery(s)/date_____

Other procedures/date?_____

Additional comments about above procedure(s):_____

OILY SKIN OR ACNE

Any acne breakout? Blackheads Whiteheads Enlarged Pores Pustules Large Pores Cysts

Do you have any history of acne or periodic breakout? Yes No If yes: Now? In Past?

Do you only experience breakout during or around your menstrual cycle? Yes No

Do you always have a pimple or some type of breakout? Yes No

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

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

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

PATIENTS INITIALS:_____ DOB:_____ TODAYS DATE:_____

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SENSITIVE AND INTOLERANT OR DRY SKIN

Do you "flush or become reddened" when eating spicy food, drink alcohol, angry, or go in the sun, etc.? Yes No
Does your skin ever get flaky or itch? Yes No If yes, is it seasonal or all the time?_____
Have you ever been diagnosed with Rosacea Yes No If yes, when was the diagnosis made?_____
Do you have difficulty healing from a cut or burn? Yes No If yes, explain_____
Have you ever had keloid scarring? If yes, explain_____

PREMATURELY AGED AND/OR HYPERPIGMENTED SKIN

Do you have facial wrinkles? Deep Wrinkles Crows Feet Fine Lines Skin Laxity
Have you been treated with: Botox? Fillers? If yes, date of last treatment_____
Do you work inside? Yes No Occupation:_____
Are your hobbies done mostly outside? Yes No Hobbies:_____
In the past (including childhood) did you live in a sun belt? Yes No If yes, where?_____
In the past have you neglected to use a sunscreen when outdoors? Yes No
Do you ever use tanning beds? Yes No If yes, when?_____
Do you currently wear a sun protection product all day, every day? Yes No
Are you willing to wear a sun protection product all day, every day? Yes No

Fitzpatrick Scale (how your skin reacts to sun exposure). How do you tan?

I Burn **II** Usually Burn **III** Sometimes Burn
IV Rarely Burn **V** Never Burn-"Brown" **VI** Never Burn-"Black"

Is your skin pigmentation (skin discoloration): Even Uneven Birthmark(s) Pregnancy Mask
What is your Ethnicity and Race (heritage)?_____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1._____
2._____

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

Face Neck Chest Back Other:_____

Patient Signature:	Date:
Technician Signature:	Date:
M.D. Signature:	Date:

PATIENTS INITIALS:_____ DOB:_____ TODAYS DATE:_____