



Skincare Intake Form

Patient Name _____ DOB ____/____/____ Date _____

Please fill in your skin type information as requested below.

Do you have sensitive skin on your face (easily irritated, breaks out in a rash in response to products)? (please circle) Never Sometimes Often Always

Do you have dry, normal, combination or oily skin?

- _____ **Oily-** skin which is often oily or greasy. A person with oily skin will feel "sticky" by late afternoon.
- _____ **Combination-** skin which is sometimes dry and sometimes oily or dry in some areas and oily in others.
- _____ **Normal-** skin which is neither dry nor oily most of the time.
- _____ **Dry-** skin which is rough or gets mild flakes if a daily moisturizer isn't used and often feels tight after washing.

Yes / No Have you ever had a reaction to skincare products? If so, what type of products and what type of reaction developed?

Yes / No Are there skincare products that you have used that you feel were not effective? If yes, please describe:

Which products do you currently use? (please list specific brand & name of product and topical medications):

<i>AM</i>	<i>PM</i>
Cleanser _____	_____
Toner _____	_____
Scrub/Mask _____	_____
Treatment/Serum _____	_____
Moisturizer _____	_____
Sunscreen _____	_____
Eye Cream _____	_____
Other _____	_____

If you do not wear sunscreen daily, how often do you use sunscreen and what SPF level?
Face _____ Body _____

Please check off your specific concerns as listed below. Rank those checked 1-10 rating your concern? (1 being the most 10 being the least)

- | | | | |
|--------------------------|--------------------------|------------------------|------------------------|
| _____ Moisturizing, face | _____ Moisturizing, body | _____ Anti-aging, face | _____ Anti-aging, body |
| _____ Lightening | _____ Firming | _____ Acne | _____ Rosacea |
| _____ Sun protection | _____ Pampering | _____ Healing | _____ Other _____ |

Notes: _____

See Skin Wizard Regimen Sheet _____ for recommended skincare program.

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