

Biophora Skin Evaluation:

Name: _____ **Age:** _____ **M or F** **Date:** _____

How do you want to improve your skin? (Circle: face, neck, chest, back, hands or other?)

What is your present skin care regime and brand of skin care products? Day and night

Have you ever seen a doctor for your skin? Why? _____

Are you pregnant or lactating? _____

Do you get cold sores? _____ How often? _____ When was the last one? _____

Have you ever used Accutane? _____ How long ago? _____ For how long? _____

What topical or oral medications do you use or have you used? _____

Acne? _____ Retin-A? _____ Glycolic Acid? _____ Herbal? _____ Other? _____

Tranquilizer? _____ Antibiotics? _____ Hormones or Birth Control? _____ Diuretics? _____

Sensitivity

Have you ever had a skin allergy? ___ Cosmetics? ___ Aspirin? ___ Rashes? ___ Latex? ___ Pineapple or Papaya? ___

Free Radical Exposure

Do you smoke? _____ How much? _____

Do you consume alcohol? _____ How much? _____

Do you maintain a regular diet? _____

Do you exercise? _____ Frequency? _____

Do you take vitamins? _____ Multi? _____ Other? _____

Hormones

Do you have regular periods? _____

Are you going through menopause? _____

During pregnancy, did you ever get hyperpigmentation or masking? _____

Pigmentation: How does your skin tan?

I - Always Burn _____

Pigmentation Even? _____

II - Usually Burn _____

Pigmentation Uneven? _____

III - Sometimes Burn _____

Acne Scars? _____

IV - Rarely Burn _____

Birthmarks? _____

V - Never Burn (brown) _____

Other? _____

VI - Never Burn (black) _____

Vascularity

Broken Capillaries? Nose area _____ Cheek area _____ Chin Area _____ Forehead _____ Entire Face _____

Acne: Do you have a history of acne _____? and/or periodic breakouts? _____

How noticeable are your pores? _____

Pimples? _____ White-heads? _____ Blackheads? _____ Enlarged pores? _____ Flakiness? _____ Cysts? _____

Facial Wrinkles: Deep wrinkles? _____ Crow's Feet? _____ Fine Lines? _____

Skin Type:

Does your skin ever flake or feel tight and dry? _____ Frequently _____ Occasionally _____ Never _____

Is your skin ever shiny a few hours after cleansing? _____ Frequently _____ Occasionally _____ Never _____

How often do you experience blackheads or blemishes? _____ Frequently _____ Occasionally _____ Never _____

Ability to Heal:

Does your skin appear fragile or burn easily? _____

Do you form thick or raised scarring from a cut or burn? _____

Do you have any health problems? _____

Do you wax or use depilatories on your face? _____ How long ago? _____

Have you ever gotten a cold sore? _____

Sun History and Skin care Lifestyle:

Have you or anyone in your family had skin cancer? _____ Where? _____

What percentage of time do you spend in the sun? Summer _____ Winter _____

Do you use sun block daily? _____ Brand? _____

How quickly do you want to see your skin improve? (strength & endurance) _____

Physician/Technician Signature: _____ Date: _____

Patient Signature: _____ Date: _____