Biophora Skin Evaluation:

Name: **Age:** **Date:** **Phone:**

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

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___

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

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___

Do you have any serious health issues?

___

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? ______________

Sensitivity

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_________________
II – Usually Burn_________________
III – Sometimes Burn_____________
IV – Rarely Burn_________________
V – Never Burn (brown) ___________
VI – Never Burn (black) ___________

Pigmentation Even? ___________________
Pigmentation Uneven? ________________
Acne Scars? _________________________
Birthmarks? _________________________
Other? ______________________________
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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______

Facial / Laser Procedures

Hair removal? Yes ______ No ______ Date of Treatment ______
Fractional or Co2 Laser? Yes ______ No ______ Date of Treatment ______
Tightening procedure? Yes ______ No ______ Date of Treatment ______
Microneedling? Yes ______ No ______ Date of Treatment ______

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? ____
Photosensitivity to: Tranquilizers? __________ Antibiotics? ___________ Hormones or Birth Control? _______

Comments or Concerns:

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Signature: ____Date: _________________________________