EnteBella
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Scottsdale, AZ 85254
480.278.7233

MEDICAL SKINCARE ASSESSMENT

PATIENT'S NAME _____ Today's Date_____

Date of Birth _____

PERSONAL HISTORY

Are you currently seeing a physician for any reason? Yes No

If yes, explain reason _____

Do you have any health problems? Yes No

If yes, list _____

Do you have any allergies or skin sensitivities? Yes No

If yes, list all allergies/skin sensitivities _____

Do you currently take any oral medications (prescriptive pharmaceuticals)? Yes No

(include: oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension etc.)

If yes, list all oral medications_____

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_____

Do you smoke?	Yes	No	If yes, how much/often?_____
Do you consume alcohol?	Yes	No	If yes, frequency/amount_____
Do you have a healthy diet?	Yes	No	List any dietary concerns_____
Do you exercise?	Yes	No	If yes, how often? Type(s)_____
Do you take vitamins?	Yes	No	If yes, what type(s)?_____
Do you drink water?	Yes	No	If yes, how many glasses per day?_____

For women only:

Do you have regular periods?	Yes	No
Are you going through menopause?	Yes	No

Are you trying to become pregnant? Yes No Are you in a fertility program? Yes No

Are you pregnant or lactating? Yes No Have you ever been pregnant? Yes No

If yes, during pregnancy did you ever experience hyperpigmentation or a "pregnancy mask"? Yes No

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 Peel(s)	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? _____

Patient Signature: _____ Date:_____

Technician Signature: _____ Date: _____