

Dr. Ben Lee
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Englewood, CO 80113
303-783-9997
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Plastic Surgeon Date: _____

Last Name Middle Initial First Name

Nickname (Alias) E-mail Address (For Skin Care Discounts)

Street Address

City State Zip Code

Gender: Female Male (circle one) Date of Birth: ___/___/___ Age: _____

_(_____) _____ _(_____) _____ (_____) _____
Home Phone Cell Phone Work Phone

Employer

Student? Where? Occupation

Marital Status: Single Married Separated Divorced Widow(er)

SKIN EVALUATION

Patient Name _____ Age _____ Date _____

Have you ever seen a dermatologist for you skin? Yes No

Have you previously had a:

Chemical Peel? Yes No
Type of peel _____ Date _____

Laser Resurfacing? Yes No
Type/Depth(If known) _____ Date _____

Facial Surgery? Yes No
Procedure _____ Date _____

Are you pregnant or lactating? Yes No

Are you taking Accutane? Yes No

Have you ever taken Accutane? Yes No

What topical medications do you use or have you used? Retin A _____ Glycolic Acid _____
Other _____

What oral medications do you use or have you used? Antibiotics _____
Hormones/Birth Control _____ Tranquilizer _____ Diuretics _____

HYPERSENSITIVITY AND FRAQLITY:

Have you ever had a skin allergy? Yes No
To: Cosmetics _____ Fabrics _____ Aspirin _____ Other _____

FREE RADICAL EXPOSURE:

Do you smoke? Yes No How Much? _____
Do you consume alcohol? Yes No How Much? _____
Do you exercise? Yes No How Much? _____
Do you take vitamins? Yes No Multi-Vitamin _____ Other _____

HORMONES:

Do you have regular periods? Yes No
Are you going through menopause? Yes No
During pregnancy did you ever get hyper pigmentation or masking? Yes No

PIGMENTATION: (Fitzpatrick Scale)

How do you tan? Please mark the most accurate answer

(I) Burn _____ (II) Usually Burn _____ (III) Sometimes Burn _____
(IV) Rarely Burn _____ (V) Never Burn-Brown _____
(VI) Never Burn-Black _____

Pigmentation Even _____ Uneven _____ Birthmark _____ Pregnancy Mask _____

VASCULARITY: (Broken Capillaries)

Chin _____ Forehead _____ Entire Face _____ Nose _____ Cheek _____

ACNE:

Do you have any history of acne or periodic breakouts? Yes No
Pimples _____ Whiteheads _____ Blackheads _____ Enlarged Pores _____
Acne Scars _____ Cysts _____ Flakiness _____

Facial Wrinkles: Deep wrinkles _____ Crows feet _____ Fine lines _____

SKIN TYPE:

Does your skin ever flake or feel tight and dry? Frequently _____ Occasionally _____ Very Rarely _____
Is your skin ever shiny a few hours after cleansing? Frequently _____ Occasionally _____ Very Rarely _____
How often do you experience blackheads/blemishes? Frequently _____ Occasionally _____ Very Rarely _____
How noticeable are your pores? Very _____ T-Zone _____ Not Very _____

ABILITY TO HEAL:

Does your skin appear fragile or burn easily?	Yes	No
Do you form thick or raised scarring from a cut or burn?	Yes	No
Do you have any health problems?	Yes	No
Do you wax or use depilatories on you face?	Yes	No
Do you ever get cold sores?	Yes	No

SUN HISTORY & LIFESTYLE:

Do you work inside or outside? _____
Are your hobbies done mostly inside or outside? _____
In the past, (including childhood) did you live in the sun belt? _____
In the past have you neglected to use a sun block when outdoors? _____

Nationality ? (optional) _____

Have you or any members of your family ever had skin cancer? _____

Anatomical location: _____

How do you want to improve your skin? _____

What specific areas do you want to treat? Face _____ Neck _____
Chest _____ Back _____

Patient Signature: _____ Date: _____

Technician Signature: _____ Date: _____