Graper • Harper
Cosmetic Surgery

Robert Graper, MD FACS • **Garrett Harper**, MD

Skin Care

Name of Patient: ______________________________

Skin Concerns

☐ Acne
☐ Acne scars
☐ Lesions/Growths
☐ Age spots
☐ Birthmarks
☐ Eczema
☐ Freckles
☐ Hair Removal
☐ Brown spots
☐ Large pores
☐ Laxity
☐ Photoaging
☐ Port wine stains
☐ Psoriasis
☐ Wrinkles
☐ Scar
☐ Skin texture
☐ Uneven skin tone
☐ Vascular lesions/Red spots

Skin Concerns Duration

Time

☐ 1 ☐ 4 ☐ 7 ☐ 10 ☐ > 12
☐ 2 ☐ 5 ☐ 8 ☐ 11
☐ 3 ☐ 6 ☐ 9 ☐ 12

Unit

☐ Day ☐ Week ☐ Year ☐ Patient unsure
☐ Days ☐ Weeks ☐ Years

Areas I would like to improve are:

☐ Forehead
☐ Browline
☐ Around eyes
☐ Cheeks
☐ Around the mouth
☐ Lips
☐ Chin
☐ Neck
☐ Underarms
☐ Arms
☐ Hands
☐ Chest
☐ Back

Current Skin Care (AM/PM) Routine

	AM Routine	PM Routine
Cleanser		
Toner		
Antioxidant		
Bleach		
Retinoid		
Moisturizers		
Eye Creams		
Sunscreens		
Notes		

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Please list all medications (including aspirin, vitamins and over-the-counter medications) that you are presently taking. If none, write "none."

Name of medication	Reason for medication

Please list allergies, if none, please write "none."

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

What is your ethnic background?

☐ Caucasian ☐ Asian ☐ Native American ☐ Eastern Mediterranean
☐ African-American ☐ Hispanic ☐ Arab ☐ Many

HIV Cert

☐ I certify that I am not HIV positive, have AIDS or Hepatitis C.

Is your skin?

☐ Dry ☐ Oily ☐ Combination ☐ Acne prone

Have you ever had a skin allergy?

☐ Yes ☐ No

Do you have a history of acne or periodic breakouts?

☐ Yes ☐ No

Have you ever had an adverse reaction after using a skin care regimen?

☐ Yes ☐ No

Physical History

	Yes	No	Details
Do you wax or use depilatories on your face?	☐	☐	________
Do you have a history of cold sores?	☐	☐	________
Have you had any active lesions in the last 4-6 weeks?	☐	☐	________
Have you had chemotherapy or radiation?	☐	☐	________
Have you had facial surgery, facial peels, laser surgery, Microdermabrasion, recent Botox, Restylane or Juvederm?	☐	☐	________
Have you or any member of your family had skin cancer?	☐	☐	________
Are you active outdoors?	☐	☐	________
In the past, have you negeclted to use sunscreen when outdoors?	☐	☐	________
Do you use DAILY sun protection?	☐	☐	________
Do you wear contacts?	☐	☐	________
Is your skin fragile or bruise easily?	☐	☐	________
Do you form thick or raised scars?	☐	☐	________
Have you ever seen a Dermatologist?	☐	☐	________
Do you take vitamins or food supplements?	☐	☐	________
Do you have a history of chronic acne?	☐	☐	________
Do you have a history of skin sensitivity?	☐	☐	________
HAVE YOU EVER TAKEN ACCUTANE?	☐	☐	________
Do you smoke?	☐	☐	________
Do you consume alcohol?	☐	☐	________
FOR WOMEN ONLY			
Are you pregnant?	☐	☐	________
Are you going through menopause?	☐	☐	________
During pregnancy, did you get hyperpigmentation or masking?	☐	☐	________

Check any topic medications (Rx or OTC) you use or have used:

- ☐ Acne
- ☐ Glycolic Acid
- ☐ Differin
- ☐ Retin-A/Renova
- ☐ Tazorac
- ☐ Other ________

Are you currently taking or have you ever used:

- ☐ Tranquilizers
- ☐ Birth Control/Hormones
- ☐ Allergy Medications
- ☐ Antibiotics
- ☐ Antidepressants
- ☐ Coumadin
- ☐ Diuretics
- ☐ Steroids
- ☐ Aspirin