SPALDING DRIVE
PLASTIC SURGERY & DERMATOLOGY

Skin Care Consultation

What is your primary skin care concern?

What have been your primary problems in the past?

Please circle 3 things you would like to improve about your skin, and rate them 1-2-3.

Lines | Wrinkles | Rough Texture | Dull | Pores | Blotchiness | Dry & Tight | Age Spots | Breakouts | Oiliness | Prevention

How would you like to improve your skin over the next 6 months?

Do you have sensitive skin? ☐ Yes ☐ No (If yes, please explain)

Have you ever experienced an allergic reaction to skin care products? ☐ Yes ☐ No (If yes, please explain)

Do you have occasional or recurring skin problems? Are you experiencing them today?

Do you have a history of chronic acne? ☐ Yes ☐ No Chronic skin sensitivity? ☐ Yes ☐ No

List your current skin care routine. List the brand names next to the products used.

Product Type	Brand	Frequency per		Day	Night	Week
Cleansers		x		D	N	W
Exfoliants		x		D	N	W
Toners		x		D	N	W
Moisturizers		x		D	N	W
AHA		x		D	N	W
Masks		x		D	N	W
Eye Gel/Creams		x		D	N	W
Serums		x		D	N	W
Sun Protection		x		D	N	W