Central Ohio Plastic Surgery, Inc.
Jason B. Lichten, MD, FACS

Name: _____ **Age:**____ **Date of Birth:**_____

Skin Care Analysis

Goals:
How do you want to improve your skin?_____
_____

What kind of results are you looking for?

___Diminish fine lines & wrinkles	___Improve texture of the skin
___Even out skin tone	___Hydrate the skin
___Clear up acne breakouts	___Decrease oiliness
___Lessen number of blackheads	___Lighten "age" spots or freckles
___Minimize size of pores	___Minimize undereye puffiness or bags
___Remove unwanted hair	___Fuller lips
___ Look my best for a special day	___Optimize my skin care routine

What specific areas do you want to treat? ___Face ___Chest ___Back
___Hands ___Arms ___Legs Other_____

Your Skin:
In the sun, do you: ___Always Burn ___Usually Burn ___Burn then Tan
___Usually Tan _____Always Tan

Do you get/ do you have ___Pimples ___Whiteheads/Blackheads ___Enlarged Pores ___Flakiness ___Acne Scars

Is your skin ____Dry ____Normal ____Oily _____Combination

Where do you have wrinkles ___Forehead ___Crow's Feet
___Between Eyes (11s) ___Around lips ___Next to mouth (parenthesis)
___I don't have any wrinkles

What products have you used to clean your face? _____

What are you using now to clean your face? _____

What kind of makeup do you use? _____

Have you ever used ___Retin A ___Hydroquinone ___Acutane ___Niacin
___Benzoyl Peroxide ___Salicylic Acid
___Antibiotics for skin problems ___ Hormones or Birth Control

Have you ever had a chemical peel? _____Yes ____No

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General Health:
How would you describe your general health? _____

Have you or any member of your family had skin cancer? ___Yes ___No
If yes, who?_____ What part of the body?_____

Do you get cold sores? _____Yes ____No

Have you ever had a skin allergy? ____Yes ___No
If yes, to ____Cosmetics ____ Fabrics _____Latex ___Sunscreen ___Other _____

Have you ever had cosmetic surgery? _____Yes ____No
If yes, what part of the body? _____ When? _____

Are you pregnant or nursing? ___Yes ___No

Do you now or did you ever smoke? ___Yes ___No If yes, how much? _____

Do you consume alcohol? ___Yes ___No If yes, how much? _____

Do you take vitamins? ___Yes ___No If yes, what kind? _____

Sun History:
What percentage of time do you spend in the sun? Summer____% Winter____%

How many blistering sunburns have you ever had? _____

Do you go to tanning beds? ____Frequently ____Sometimes ___Never

How often do you use sunscreen? _____

Hair Removal:
What methods of hair removal have you used? ___Shaving ___Waxing
___ Depilatory Creams ___Electrolysis ___Laser Hair Removal

Other Procedures:
Are you interested other cosmetic procedures? ___Yes ___No
___Breast Augmentation ___Breast Lift ___ Breast Reduction ___Facelift
___Tummy Tuck ___Liposuction ___Browlift Other _____

The above information is accurate and complete to the best of my knowledge.

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Signature: _____