Skin Assessment Form

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Contact Number: _____

Email: _____

MEDICAL HISTORY

Any known skin conditions or allergies? Please specify:

Current medications or treatments being taken:

LIFESTYLE AND HABITS

Occupation: _____

Sun exposure habits (including outdoor activities and sunscreen usage):

Smoking or alcohol consumption:

Sleep patterns:

SKIN CONCERNS

What are your primary skin concerns? (e.g., acne, dryness, redness, aging, etc.):

How long have you been experiencing these concerns? (2 lines)

Have you tried any treatments or products to address these concerns? If yes, please provide details:

SKIN TYPE AND CHARACTERISTICS

Skin type: _____ Skin tone: _____

Skin texture: _____ Presence of visible pores: _____

Presence of fine lines or wrinkles: _____

CURRENT SKINCARE ROUTINE

Cleanser: _____ Toner: _____

Moisturizer: _____ Sunscreen: _____

Additional products or treatments: _____

Additional Notes or Comments: