Beaumont Health Integrative Medicine
Skin Care Intake

Name:_____**DOB**_____
MRN (Office use):_____

Please circle any conditions you are currently experiencing:

Diabetes	Migraines	Cold Sores	Headaches	Fainting
Claustrophobia	Shingles	Cancer	Warts	TMJ
Skin Irritations				

Please explain:	Office Use:

Have you experienced in the past 14 days:

Facial cosmetic surgery	Chemical peels	Botox injections	Extractions
Collagen injections	Laser surfacing	Microdermabrasion	Laser hair removal
Laser surfacing	Self tanning	Resylane/ruevaderm	Collagen

Please explain:	Office Use:

Have you experienced in the last 6 weeks:

Shaving	Waxing	Electrolysis	Plucking/tweezing
Stringing	Depilatories	Laser hair removal	Sugaring

Please explain:	Office Use:

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Are you currently taking any of these listed prescriptions:
Tretinoin (Retin A, Micro Retin A, Renova, Ativa) Differin (Adepalene)

Axdliaci Acid (Axelex, Rinacea)	Tazarotene
Accutane (Isotretinioin)	Triluma

Other:	Office Use:

What are your skin concerns? Please check any and all that apply.

Breakouts/Acne	Blackheads/whiteheads	Oil/shine	Rosacea	Flaky skin
Redness/Ruddiness	Uneven Skin Tone	Sun Damage	Dehydrated	Anti-aging
Dull/Dry Skin	Flaky skin	Sun/Liver/Brown Spots		

Other:	Office Use:

Please circle any of the following products you currently use at home for skin care maintenance:

Cleanser	Toner	Vitamin C	Exfoliant/scrub	Specialty products
SPF	Mask	Retin A	Glycolic acid (AHA)	Resorcinol
Salicylic acid	Sulfur	Hydrocortisone (HC)	Hydoquinone (HQ)	Moisturizer

Please explain:	Office Use:

What is your skin type? _____ Dry **_____**Combination **_____**Oily

Are you currently wearing contact lens? _____ Yes **_____**No
If "Yes", are your contacts _____soft lens **_____**hard/gas permeable

BEAUMONT HEALTH INTEGRATIVE MEDICINE
ONCOLOGY FOR SKIN CARE

Cancer diagnosis:_____

Did you have cancer related surgery? ____Yes ____No
If yes, when was your surgery date?_____
Did you have lymph nodes removed? __ Yes___No
If lymph nodes were removed, how many? _____

Have you been treated for lymphedema? ____Yes ____No
Are you currently experiencing heaviness or swelling in the affected side arm or leg?
_____Yes _____ No

Are you currently receiving treatment for cancer? ____Yes ____No
When was your most recent chemotherapy date? _____
What date did your chemotherapy start? _____
What date will your chemotherapy end? _____

Do you have a port? _____Yes ____No
If so, where is it placed? _____

Are you receiving radiation treatment? ____Yes ____No
If so, what date did your radiation treatment start? _____
What date will your radiation treatment end?_____

Are you noticing changes in your skin while receiving treatment? ____Yes ____No
If "Yes" what changes/concerns do you have? _____
_____
_____

Are you taking anti-coagulant (blood thinner)?_____Yes _____No

Are you experiencing neuropathy pain in hands or feet? (ex. pins & needles, numbness)
_____

Cancer related medications presently
taking:_____
_____