Skin Assessment Form

Patient Information

Name: _____

Date of Birth: _____ 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?

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: