



SKIN TYPING WORKSHEET

SCORE	0	1	2	3	4
What is the color of your eyes?	<input type="checkbox"/> Light Blue, Gray, Light Green	<input type="checkbox"/> Blue, Gray or Green	<input type="checkbox"/> Dark Blue or Hazel	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Brownish Black
What is the natural color fo your hair?	<input type="checkbox"/> Sandy Red	<input type="checkbox"/> Blonde	<input type="checkbox"/> Chestnut, Dark Blonde	<input type="checkbox"/> Dark Brown	<input type="checkbox"/> Black
What is the color of your skin? <i>(Non-exposed areas)</i>	<input type="checkbox"/> Reddish	<input type="checkbox"/> Very Pale	<input type="checkbox"/> Pale with Beige Tint	<input type="checkbox"/> Light Brown	<input type="checkbox"/> Dark Brown
Do you have freckles on unexposed areas?	<input type="checkbox"/> Many	<input type="checkbox"/> Several	<input type="checkbox"/> Few	<input type="checkbox"/> Incidental	<input type="checkbox"/> None

Total score for GENETIC DISPOSITION _____

SCORE	0	1	2	3	4
What happens when you stay in the sub too long?	<input type="checkbox"/> Painful red-ness, blistering, peeling	<input type="checkbox"/> Blistering follo-woed by peeling	<input type="checkbox"/> Burns some-times followed by peeling	<input type="checkbox"/> Rare Burns	<input type="checkbox"/> Never had burns
To what degree do you turn brown?	<input type="checkbox"/> Hardly or not at all	<input type="checkbox"/> Light color tan	<input type="checkbox"/> Reasonable tan	<input type="checkbox"/> Tans easily	<input type="checkbox"/> Turns dark brown quickly
Do you turn brown after several houes of sun exposure?	<input type="checkbox"/> Never	<input type="checkbox"/> Seldom	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
How does your face react to the sun?	<input type="checkbox"/> Very sensitive	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Normal	<input type="checkbox"/> Very resistant	<input type="checkbox"/> Never had a problem

Total score for REACTION TO SUN EXPOSURE _____

SCORE	0	1	2	3	4
When was the last time you exposed your body to the sun too long?	<input type="checkbox"/> More than 3 months ago	<input type="checkbox"/> 2-3 months ago	<input type="checkbox"/> 1-2 months ago	<input type="checkbox"/> Less than a month ago	<input type="checkbox"/> Less than 2 weeks ago
How frequently do you expose the area to be treated to the sun?	<input type="checkbox"/> Never	<input type="checkbox"/> Hardly ever	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always

SUMMARY

Total score for Genetic Disposition _____

Total score for Reaction to Sun _____

Total score for Tanning Habits _____

Total score for _____

Your Fitzpatrick Skin Type	
Skin type score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Above 30	V-VI

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- | | | |
|-------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Uneven Skin Tone | <input type="checkbox"/> Visible Exposed Blood Vessels | <input type="checkbox"/> Hard Bumps Under Skin |
| <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Clogged Pores | <input type="checkbox"/> Blackheads/Whiteheads |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive Oiliness | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry Patches | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown Spots (Hyperpigmentation) | <input type="checkbox"/> White Spots (Hypopigmentation) |

What is your skin type: Dry Combination Oily Normal

Please check the products you currently use and list the BRAND NAMES of cosmetic products:

- | | | |
|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Cleanser _____ | <input type="checkbox"/> Soap _____ | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____ |
| <input type="checkbox"/> Eye Cream _____ | <input type="checkbox"/> Astringent _____ | <input type="checkbox"/> Glycolic Wash/Cleanser |
| <input type="checkbox"/> Scrub _____ | <input type="checkbox"/> Sunscreen _____ | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream _____ | <input type="checkbox"/> Vitamin C Creme _____ | <input type="checkbox"/> Alpha or Betahydroxy Cream |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, and anti-aging or hyperpigmentation?

Please List:

Yes No

Have you ever had any of the following wrinkle filters or implants:

- Collagen Restylane Perlane Hylaform Juvederm® Silicone Radiesse

If so, when? _____ What are? _____ By Whom? _____

Have you ever undergone any of the following treatments?

- Cosmetic Surgery What area of the body? _____ When was it done? _____
- BOTOX® What area of the face? _____ When was it done? _____
- Acid Peel Accutane Microdermabrasion Lasers Which one? _____
- When and where was it done? _____

Are currently removing hair by any of the following methods?

- Waxing Tweezing "Nair" type products Electrolysis Laser Hair Removal

If so, when? _____ What area? _____ What type of laser _____

I certify that the above information is correct to the best of my knowledge. _____

Patient Signature

IM&P Wellness Center Notes: