



G R E G R U F F, M D

SKIN EVALUATION

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Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_
Last First Middle

- Have you ever seen a dermatologist for your skin?
Do you have a history of periodic breakouts?
What topical medications do you use or have you used?
What oral medications do you use or have you used?
Describe any skin reactions to cosmetic products
List any allergies to medications
Do you smoke?
Do you consume alcohol?
Do you have a regular diet?
Do you exercise regularly?
Do you take vitamins daily?
Do have regular menstrual periods?
Are you going through menopause?
Have you ever had melasma (mask of pregnancy)?
How much water do you consume daily?

Sun Reaction (What happens to your skin when you're exposed to sun without protection for 1 hour)

- Always burns, never tans
Always burns, sometimes tans
Sometimes burns, sometimes tans
Always tans

Do you have concerns with any of the following

- Pimples, Cysts, Sun damage, Whiteheads, Crowsfeet, Dark spots, Blackheads, Flakiness, dry skin, Excess oil, Enlarged pores, Deep wrinkles, Laxity of skin, Acne scars, Fine lines, Uneven tones

- Does your skin ever feel tight or dry?
By mid-afternoon, is your skin shiny?
How often do you have breakouts?
How noticeable are your pores?
Do you form thick or raised scarring?
Do you ever get cold sores or fever blisters?
Has anyone in your family ever had skin cancer?
What percentage of time do you spend in the sun? Summer Winter

How would you like to improve your skin? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_