



LAKE SHORE

FACIAL & COSMETIC SURGERY CENTER

The area leader in facial cosmetic care.

Dr. J. Ben Hengy & Dr. Andrew Mendians

Skin Analysis/Cosmetic Interest Questionnaire

Name _____ Date _____

Health issues of interest to you (please check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Skin rejuvenation | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Skin Care advice | <input type="checkbox"/> Skin care products | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Liver/Age spots | <input type="checkbox"/> Freckles | <input type="checkbox"/> Melasma | <input type="checkbox"/> Sunscreen advice |
| <input type="checkbox"/> Leg veins | <input type="checkbox"/> Facial/eye wrinkles | <input type="checkbox"/> Laser hair removal | <input type="checkbox"/> Facial veins |
| <input type="checkbox"/> Spider veins | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Port Wine Stains | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Otoplasty | <input type="checkbox"/> Chin Tuck | <input type="checkbox"/> Face lifts |
| <input type="checkbox"/> Mole removal | <input type="checkbox"/> Skin tags | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Scarring |

Please check all the areas of skin you would like examined/treated:

- | | | | | | | |
|--------------------------------|--------------------------------|-------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Scalp | <input type="checkbox"/> Chest | <input type="checkbox"/> Arms | <input type="checkbox"/> Legs | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Face | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Back | <input type="checkbox"/> Hands | <input type="checkbox"/> Feet | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Underarms | <input type="checkbox"/> Genitals | <input type="checkbox"/> Neck |

Please check all that apply:

- | | | | | |
|--|---------------------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> Hard lumps under skin | <input type="checkbox"/> Facial Scars | <input type="checkbox"/> Sun damage | <input type="checkbox"/> Blood vessels | |
| <input type="checkbox"/> Dry patches | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive hair | <input type="checkbox"/> Uneven skin tone |

Please check of you have used any of the following products:

- | | | | | |
|----------------------------------|---------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Retin A | <input type="checkbox"/> Renova | <input type="checkbox"/> Alpha Hydroxy | <input type="checkbox"/> Glycolic Acid | <input type="checkbox"/> Accutane |
|----------------------------------|---------------------------------|--|--|-----------------------------------|

If so specify duration and strength _____

Do you have any tattoos, implants or permanent makeup, in/on area to be treated: Yes No

If yes, where? _____

Please check if you are currently taking: Bactrim Tetracycline Hydrochlorothiazide

Are you taking any medications that make you sensitive to the sun? Yes No

Best description of your skin? Oily Oily/Normal Normal Normal/Dry Dry

Have you ever had laser treatment before? Yes No

Have you ever had a chemical peel? Yes No

Please list the brand names for all that apply:

Cleanser _____ Astringent _____ Moisturizer _____

Mask _____ Eye Cream _____ Sunscreen _____

Night Cream _____ Other _____

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Genetic Disposition

Score	0	1	2	3	4
Your natural eye color	Light blue, green or gray	Blue	Brown	Dark brown	Brownish/black
Natural hair color	Sandy, red	Blonde	Chestnut/dark blonde	Dark brown	Black
Color of your non-exposed skin	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on unexposed areas	Many	Several	Few	Incidental	None

Total score for reaction to Sun exposure: _____

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burn followed by peeling	Rarely burn	Never burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

Total score for reaction to Sun exposure: _____

Tanning Habits

Score	0	1	2	3	4
Last exposure to Sun, tanning booth or creams	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you have sun exposure to the treatment area?	Never	Hardly ever	Sometimes	Often	Always

Total score for Tanning Habits: _____

Add up the total scores for each section for your skin type score to give you a better evaluation for your skin type.

_____ Total score for Genetic Disposition
 _____ Total score for Reaction to the Sun Exposure
 _____ Total score for Tanning Habits
 _____ Total Skin type score

Your Fitzpatrick skin type:

Skin type score	Fitzpatrick type
0-07	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

Comments: _____

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