SideStep Oncology Facial Treatment In-Take Form

About Face Skin Care | 1569 Janmar Rd. Suite B | Snellville, GA | 770.935.3223 | Treating and Delegating Physician: Dr. Tina Thompson

Client Name________________________________ **Date of Birth:**________________________________

Are you currently under the care of a physician Cancer or any other health related issues?	YES	NO	Comment
What type of Cancer have you been diagnosed with?			Comment
Is this your first diagnoses with Cancer? If No when was your last diagnose?	YES	NO	Comment
What Cancer Therapies are you currently receiving?			Duration__________________ When___________________
Do you have any allergies to products, foods or ingredients? Please list.			
What skin care concerns do you have at this time?			
What skin care products are you currently using?			
Are you currently using any topical or oral medications for your skin conditions or disorders either prescription or over the counter? If yes please describe?	YES	NO	Comment
Are you currently experiencing any skin changes due to your medical oncology therapy? If yes please describe?	YES	NO	Comment

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Do you have any excessive dryness, tightness, dry patches or skin peeling?	YES	NO	Comment
Are you experiencing any skin flushing (marked redness)?	YES	NO	Comment
Do you have any skin rashes, acne type lesions?	YES	NO	Comment
If you are receiving or had radiation therapy are you experiencing any burns, discoloration, skin peeling or radiation recall if so where?	YES	NO	Comment
Have you notice any skin discolorations such as light or dark areas? If yes where and for how long?	YES	NO	Comment
Is your skin sensitive to temperature changes, burning, itching or pain? If yes where and for how long?	YES	NO	Comment
Do you have any wounds that are not healing? If yes please describe.	YES	NO	Comment
Are you experiencing any issues with your extremities? (Swelling, peeling, redness, pain, itching)	YES	NO	Comment
Have you received any professional skin treatments recently? Such as, chemical or enzyme peels, or microderm, etc…	YES	NO	When____________________ Type______________________
	***Client Signature & Date*:**		

Please let us know all your skin care concerns:

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