RUSSAK DERMATOLOGY CLINIC

115 EAST 57TH STREET, 12TH FL, NEW YORK, NY 10022
T: 646-873-7546 WWW.RUSSAKDERMATOLOGY.COM

PATIENT HISTORY

NAME: ______________________ **DATE:** __________

1. Please indicate your key skin concerns and list corresponding body area.

- ❑ Acne scarring
- ❑ Acne/breakouts
- ❑ Abnormal scarring
- ❑ Blotchiness/redness
- ❑ Dryness
- ❑ Eczema
- ❑ Fine lines/wrinkles
- ❑ Hair loss
- ❑ Laxity/loss of volume
- ❑ Moles/abnormal skin growth
- ❑ Pigmentation
- ❑ Rash
- ❑ Rough, uneven texture
- ❑ Psoriasis
- ❑ Skin cancer
- ❑ Spider veins/vascular abnormality
- ❑ Unwanted hair
- ❑ Underarm sweating
- ❑ Other (please specify) ______________________

2. Please list previous medical treatments done to address your skin concern(s).

FOR OFFICE USE ONLY

3. Fitzpatrick Type

4. Skin condition

❑ Dry ❑ Normal ❑ Combination ❑ Oily