



Name: _____

Address: _____

Phone #1: _____ **Phone #2:** _____

Female **Male** **Age:** _____ **Referred by:** _____

Email Address: _____

Reason for consultation

- | | |
|--|---|
| <input type="checkbox"/> Acne/ Acne Scars | <input type="checkbox"/> Flushing of the skin |
| <input type="checkbox"/> Brown spots or sun damage | <input type="checkbox"/> Skin laxity/ texture |
| <input type="checkbox"/> Enlarged blood vessels | <input type="checkbox"/> Unwanted hair |
| <input type="checkbox"/> Fine lines or wrinkle | <input type="checkbox"/> CoolSculpting |

What other services are you interested in learning about during your consultation? (Please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Skin care advice | <input type="checkbox"/> Wrinkle Treatments | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Skin care products | <input type="checkbox"/> Sun spots | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Broken blood vessels | <input type="checkbox"/> Acne scars |
| <input type="checkbox"/> Juvederm | <input type="checkbox"/> Blotchy skin | <input type="checkbox"/> Lengthening eyelashes |

Other (Please explain):

Questions about skin

- How long have you been concerned about this area(s)? _____
- At what age did you notice this concern(s)? _____
- Are your present skin concern(s) getting more pronounced? Yes No
- Have you ever been treated for this concern(s)? Yes No
 If yes, when? _____
 What method? _____
 Were you happy with results? _____
- Are you currently taking medication for your skin's concern(s)? Yes No
 If yes, what is it? _____

6. What skincare products are you currently using? _____
7. What topical skin medications or products are you currently taking?
 Retin-A® Hydroquinone or bleaching agent Other _____
8. Have you ever had laser / IPL hair removal? Yes No
9. Have you ever used the following hair removal methods in the past 6 weeks?
 shaving waxing electrolysis plucking/tweezing stringing depilatories
9. Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No
10. Have you ever had treatments for pigmented lesions? Yes No
11. Do you form thick or raised scars (keloids) from cut or burns? Yes No
12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? Yes No
13. Have you had cold sores or fever blisters? Yes No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- | | | | |
|------------------------------|--------------------------|----------------------------------|--------------------------|
| Always burns, never tans | <input type="checkbox"/> | Rarely, burns, always tans | <input type="checkbox"/> |
| Always burns, sometimes tans | <input type="checkbox"/> | Brown, moderately pigmented skin | <input type="checkbox"/> |
| Sometimes burns, always tans | <input type="checkbox"/> | Black skin | <input type="checkbox"/> |

When were you last exposed to the sun or tanning booth? _____

1. Do you use self tanners? Yes No
2. Are you planning a vacation in the sun? Yes No

Personal history:

1. Do you smoke? Yes No if yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? Yes No

Medical history:

1. Are you currently under the care of a physician? Yes No. If yes, for what:

2. Do you have any of the following?
- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Any active infection | <input type="checkbox"/> Heart disease | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> Skin cancer or moles |
| <input type="checkbox"/> Dark spots of pregnancy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormone imbalance | <input type="checkbox"/> Vision deficits |
| <input type="checkbox"/> Other _____ | | |

3. Do you have allergies to any of the following? (check all that apply)

medications latex food plants anesthesia other_____

4. Do you take any of the following?

<input type="checkbox"/> Accutane	<input type="checkbox"/> Appetite depressants	<input type="checkbox"/> Insulin
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Aspirin or Ibuprofen	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Anti-coagulants	<input type="checkbox"/> Cortisone or steroids	<input type="checkbox"/> Thyroid medication
<input type="checkbox"/> Anti-depressants	<input type="checkbox"/> Hormone/contraceptives	<input type="checkbox"/> Other_____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) Yes No

For female patients:

1. Are you pregnant or trying to become pregnant? Yes No

2. Are you breast feeding? Yes No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: _____ **Date:** _____