

Patient Information

Name _____ Date _____

Address: _____ City _____ State _____ Zip _____

Hm# _____ Wk # _____ Cell Phone _____

Age _____ Date of Birth _____ Employer _____

E-mail _____ Preferred method of contact _____

Do you drink Alcoholic beverages? Y / N If yes, how frequently _____

Do you Smoke? Y / N If yes, how frequently _____

How much water do you drink daily?

Are you pregnant or trying to become so? Y / N

What skin care products or regimen do you use daily?

Are you using any products with glycolic acid, alpha-hydroxy acid or retinol? Y / N

If yes, what products _____

Procedures or products of interest to you: (check all that apply)

___ Facials ___ Acne Treatments ___ Micro-Dermabrasion

___ Chemical Peels ___ Hair Removal ___ Botox Cosmetic

___ Restylane ___ Skin Rejuvenation ___ Anti Aging Products

___ Varicose Veins ___ Spider Veins ___ Laser Micro-Peels

___ Rosacea ___ Other, please specify: _____

Have you ever received any of the above treatments?

If so, please list. _____

What type of problem are you consulting for?

- Sun spots
- Wrinkles
- Enlarged blood vessels
- Flushing of the skin
- Large pores
- Other: _____

How many years have you noticed this problem? _____

At what age did your skin problem begin? _____

Are your present skin problems getting more pronounced? Yes No

Do you have a history of keloid scarring? Yes No

Do you have a history of?

- | | |
|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Herpes sores | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Dark spots after pregnancy |
| <input type="checkbox"/> Skin injury | <input type="checkbox"/> Skin cancer, or suspicious moles |

Have you had any allergic reactions to anesthesia? Yes No

Do you have any skin related allergies? Yes No

If yes, please specify _____

Do you have any allergies to medication? Yes No

If yes, please specify _____

Do you take any medication?

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| <input type="checkbox"/> | <input type="checkbox"/> Appetite depressant(diet pills) |
| Hormones/contraceptives | |
| <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Other (please specify)_____ |

Are you taking any herbal preparations? (St. John's Wort) Yes No

If yes, list _____

Do you wear contact lenses? Yes No

Have you had cold sores or fever blisters? Yes No

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

- | | | |
|-----|--|--------------------------|
| I | Always burns, never tans | <input type="checkbox"/> |
| II | Always burns, sometimes tans | <input type="checkbox"/> |
| III | Sometimes burns, sometimes tans | <input type="checkbox"/> |
| IV | Always tans | <input type="checkbox"/> |
| V | Asian, Hispanic, Mediterranean, Middle Eastern | <input type="checkbox"/> |
| VI | Black | <input type="checkbox"/> |

When were you last exposed to the sun (or a tanning booth)?

Do you use chemical sun tanning lotions? Yes No

Are you planning a holiday in the sun? Yes No