



Name _____ Date _____

Address _____

Home Phone _____ Business Phone _____

Age _____

How did you hear about us? Newspaper Mailer Yellow Pages Internet

Other (specify) _____.

Whom may we thank for referring you? _____.

Have you visited our website? Yes No

What type of problem are you consulting for?

- | | |
|--|--|
| <input type="checkbox"/> Spots or color irregularities | <input type="checkbox"/> Hair removal |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Skin laxity |
| <input type="checkbox"/> Vein elimination | <input type="checkbox"/> Nose appearance |
| <input type="checkbox"/> Redness or Rosacea | <input type="checkbox"/> Eyelid appearance |
| <input type="checkbox"/> Acne scars | |

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

Have you ever been treated for this problem? Yes No

If yes, when? _____

By what method? _____

Are you currently taking medication for your skin problem? Yes No

If yes, which medication? _____

Are you pregnant, nursing, or planning a pregnancy soon? 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 (cold sores) | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Bruising abnormally | <input type="checkbox"/> Dark spots after pregnancy |
| <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Skin cancer, or suspicious moles |

Have you had any allergic reactions to anesthesia or local anesthetics? 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"/> Hormones/contraceptives | <input type="checkbox"/> Appetite suppressants (diet pills) |
| <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Cortisone (steroids) | <input type="checkbox"/> Other (please specify) _____ |

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

If yes, list _____

What is your daily consumption of alcohol? _____

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

Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No

Have you ever had treatments for pigmented lesions? Yes No

Prior treatment (if any) _____

Patient Signature _____

Date _____