

## Patient Consultation and History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you ever seen a specialist for your skin? YES NO

### **\*MEDICAL HISTORY**

What topical medications have you or do you use?

Acutane

Retin-A

Glycolic Acid

Hydroquinone

Other \_\_\_\_\_

What oral medication are you currently using?

Antibiotics

Hormones or Birth Control

Laxatives /Diuretics

Other \_\_\_\_\_

Do you have any health problems?

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Do you have a history of seizures? YES NO

Have you had any skin peels or microdermabrasion? YES NO

Do you get facials on a regular basis? YES NO

Have you ever had laser surgery or dermabrasion? YES NO

Have you ever had Botox or Collagen injections? YES NO

Do you have permanent makeup or tattoos? YES NO

Do you have a skincare routine? YES NO

**\*HYPERSENSITIVITY & FRAGILITY:**

Have you ever had a skin allergy?	YES	NO
Do you have any known drug allergies?	YES	NO
Do you have any nut allergies?	YES	NO
Do you experience claustrophobia?	YES	NO

**\*FREE RADICAL EXPOSURE:**

Do you smoke?	YES	NO
Do you consume alcohol?	YES	NO
Do you take vitamins?	YES	NO
How much water do you consume daily? _____		

**\*HORMONES:**

Do you have regular periods?	YES	NO
Are you pregnant or lactating?	YES	NO
Have you or are you going through menopause?	YES	NO
Have you had hyperpigmentation from pregnancy?	YES	NO
Are you trying to become pregnant in the next year?	YES	NO

**\*SUN HISTORY & LIFESTYLE:**

Do you wear a sunscreen every day?	YES	NO
Have you had prolonged sun exposure in the past 5 days?	YES	NO
Have you ever used a tanning bed?	YES	NO

If yes when and how often? \_\_\_\_\_

Do you sunbathe?	YES	NO
What is your level of stress? 1 2 3 4 5 6 7 8 9 10		
Do you have or get cold sores (Herpes)?	YES	NO
Have you had or have skin cancer?	YES	NO

What type? & Where ? \_\_\_\_\_

**\*SKIN TYPE:**

Does your skin ever feel tight or dry or flaky? Never Occasionally Often

Is your skin ever shiny a few hours after cleansing? Never Occasionally Often

How often do you experience blemishes or blackheads? Never Occasionally Often

How noticeable are your pores? Not very Very

Do you have Rosacea? YES NO

Do you have a history of acne or breakouts? YES NO

Do you have any scarring as a result from your acne? YES NO

Do you form keloids (thick raised scars)? YES NO

What specific area do you want treated?

Face Neck Chest Back Hands Forearms Other

I \_\_\_\_\_ have read and answered all questions truthfully and at anytime during my course of treatments any new problems develop I will inform my skincare provider.