

Date: _____

Name _____ DOB ____/____/____
Last First

This information is necessary for your procedure. Please answer yes or no to the following questions.

Yes No

Are you using any prescribed medications?

List: _____

Are you using any herbal medications?

List: _____

Do you take oral anti-coagulant (blood thinning) medication?

Are you allergic to any cosmetic ingredients, medications or foods?

List: _____

Are you pregnant or trying to become pregnant?

Do you use oral contraceptives?

Do you use hormone replacement therapy?

Do you smoke? How much _____ How long _____ When did you quit _____.

Do you spend a lot of time outdoors or use a tanning bed often? Do you use spray tans?

Do you have any tattoos or permanent makeup?

Do you have any allergies to eggs, egg proteins, or human albumin?

Do you have any neuromuscular or autoimmune diseases?

Do you have any allergies to latex?

Do you have a fear of needles?

Please answer the following questions:

Which concerns apply to you? (Check all that apply):

Uneven Skin Tone

Brown Spots (Hyperpigmentation)

White Spots

(Hypopigmentation)

Skin Consult Intake Form

- Enlarged Pores Under Skin**
- Acne Blackheads/Whiteheads**
- Upper Lip Lines**
- Dry Patches**
- Unwanted Body Fat**
-
- Visible Exposed Blood Vessels**
- Clogged Pores**
- Excessive Oiliness**
- Wrinkles**
- Stretch Marks**
- Hard Bumps**
-
- Skin Laxity**
- Scarring**
- Cellulite**

Other _____

What is your skin type: **Dry** **Combination** **Oily**
Normal

How much water do you consume per day? _____

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

- Cleanser** _____
- Soap** _____
- Moisturizer** _____
- Toner** _____
- Night Cream** _____
- Mask** _____
- Eye Cream** _____
- Astringent** _____
- Glycolic Wash/Cleanser** _____
- Scrub** _____
- Sunscreen** _____ **Salicylic**
- Wash/Cleanser** _____
- Vitamin A Cream** _____ **Vitamin C**
- Creams** _____
- Alpha or Beta Hydroxy Cream** _____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? Please List: _____

Have you ever had any of the following injectables or implants:

- Botox Juvederm Radiesse Restylane Perlane Silicone Hylaform
 - Collagen Lipo Dissolve
- Other: _____

If so, when was it done? _____ What area? _____

Have you had any other cosmetic surgeries/procedures? _____
When? _____ Were you pleased with the results? _____

Please check any health problems, past or present:

- Seizures Liver Disease Skin Cancer
 - Hepatitis Asthma Hormonal Problems
 - Diabetes Cystic Acne Thyroid
 - Cancer High Blood Pressure Heart Problems
 - Collagen (Lupus, Sarcoid, Scleroderma) Vasovagal Syncope/Fainting
- Other: _____

Do you have any of the following chronic skin disorders:

- Psoriasis Dermatitis Eczema Keloid Scarring
- Fever Blisters Cold Sores Sun Blisters Herpes
- Simplex/Blisters
- Rosacea Melasama

Have you ever undergone any of the following treatments?

- Microdermabrasion Acid Peel Cosmetic Surgery
- Accutane

Please Explain: _____

Provider Name

Date