Patient Consultation and History Form:

Patient Name: ____Date: ___________________________

Address: ____

City:______________________________________ State:_______ Zip code:__________________

Home Phone:(________)______________________ Cell Phone:(________)____________________

Birth Date: _____/______/__________

Would you like current specials sent to you? YES NO

Email address: ____

MEDICAL HISTORY

Are you experiencing any health problems? YES NO

If yes, what? ____

____

What oral medications are you currently using? (In the past 2-3 months)

Antibiotics Hormones Birth Control Diuretics Thyroid Blood Thinner

Other: ____

Are you Diabetic? YES NO

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? **YES NO**

Circle your level of stress (1 low, 10 high) 1 2 3 4 5 6 7 8 9 10

At any time in the present or the past have you gotten cold sore or herpes? YES NO

SKIN HISTORY

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

If Yes When/Why? ____

Have you ever had a skin allergy? YES NO

Do you have any known drug or food allergies? YES NO

If yes, to what drug or food? ____

Do you experience any claustrophobia? YES NO

What type of massage do you prefer? Light Firm

What level do you consider your pain threshold to be? Low High

What temperature of water do you use to cleanse? Cool Warm Hot

What skin care products are you using currently? ___________________________________

____

Are you using any eye cream? YES NO

Are you using a sunscreen every day? YES NO

Have you had any enzyme or chemical peels? YES NO

Have you ever had a microdermabrasion treatment? YES NO

Have you used Accutane? YES NO

What topical medications do you use or have you used?____

Retin-A Glycolic Acid Lactic Acid Salicylic Acid Other: ______________________________

Have you ever had laser procedure? YES NO

If yes, in what area? ____

How long ago? ____

Have you ever had **facial plastic surgery**? YES NO

If yes, in what area? ____

How long ago? ____

Have you ever had any Injectables? Botox Radiesse Juvederm None

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VASCULARITY

Broken Capillaries: Nose Cheeks Chin Forehead Entire Face

Do you blush easily? YES NO

Have you been told you have Rosacea? YES NO

SUN HISTORY

Have you been in the sun lately? YES NO

If yes, when? ____

Are you going on vacation any time soon? YES NO

If yes, when? ____

What amount of time do you spend in the sun in the summer: ½ HR 1HR 2 HRS or more

In the past have you lived in a Sunbelt and sunbathed?		YES	NO	
In the past have you neglected to use sun block?		YES	NO	
Do you go to a tanning salon?		YES	No	
Do you have?	Birthmarks	Freckles	Redness	Pregnancy Mask

FREE RADICAL EXPOSURE

Do you smoke?	YES	NO
Do you consume alcohol?	YES	NO
Do you have a healthy diet?	YES	NO
Do you exercise?	YES	NO
Do you take vitamins/supplements?	YES	NO
How much water do you consume daily?	______________oz.	

WOMEN ONLY

Do you have regular periods?	YES	NO
Are you going through menopause?	YES	NO
During pregnancy, did you get hyperpigmentation or masking?	YES	NO
Are taking oral contraception?	YES	NO
Are you trying to become pregnant?	YES	NO
Are you pregnant or lactating?	YES	NO
Are you currently having or due for your menstrual period?	YES	NO

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SKIN TYPE

Does your skin ever flake or feel tight and dry?	Frequently	Occasionally	Rarely
Is your skin ever shiny a few hours after cleansing?	Frequently	Occasionally	Rarely
How often do you experience blackheads or blemishes?	Frequently	Occasionally	Rarely
What type of blemish do you get?	White heads	Black heads	

What skin type do you consider yourself to have? Oily Acneic Dry Normal Mature Combination

Does your skin appear sensitive?	YES	NO
Do you form thick or raised scars?	YES	NO
Do you use wax or other depilatories?	YES	NO

FITZPATRICK CLASSIFICATION SYSTEM (Please check one skin type below which best suits)

Skin Type:	Skin Color:	Characteristics:
☐ I	White	Always burns, never tans
☐ II	White	Usually burns, tans less than average
☐ III	White	Sometimes mild burns, tans about average
☐ IV	White	Rarely burns, tans more than average
☐ V	Brown	Rarely burns, tans profusely
☐ VI	Black	Never burns, deeply pigmented

Patient Objective

What specific areas do you want to treat and why? (Please check all that apply and be specific.)

- ☐ Face____
- ☐ Eyes____
- ☐ Cheeks____
- ☐ Neck____
- ☐ Chest____
- ☐ Back____
- ☐ Hands____
- ☐ Forearms____
- ☐ Other____

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What Services Would You Like To Learn More About? (Please check all that apply)

- ☐ **Laser 360 Program**
- ☐ **Individual Laser Treatments**
- ☐ **Injectables**
- ☐ **Advanced Exfoliation**
- ☐ **Anti-Aging**
- ☐ **Roll-CIT**
- ☐ **Laser Hair Removal**
- ☐ **Skin Tightening**
- ☐ **Body Contouring**
- ☐ **Acne Treatments**
- ☐ **Facials**
- ☐ **GliSODin Skin Nutrients**
- ☐ **Medical Grade Home Care Products**
- ☐ **Medical Grade Mineral Make up**