

Patient Consultation

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Are you pregnant or lactating? Yes ___ No ___

Do you wear contact lenses? Yes ___ No ___

Do you have permanent makeup? Yes ___ No ___ (If so, what areas of the face?) _____

Do you currently use or receive dipilatories or waxing? Yes ___ No ___ (Discontinue use 5 days pre-and post-treatment.)

Do you currently have a sunburned / wind burned / red face? Yes ___ No ___ Why? _____

Are you in the habit of going to tanning booths? Yes ___ No ___ (If within the past 14 days, decline treatment; we recommend this practice is discontinued all together.

Are you currently on a daily skincare regimen? Yes ___ No ___ (If yes, what products?) _____

Are you applying any topical medications at this time? Yes ___ No ___ which one(s)? _____

(High percentages of certain ingredients may cause increased sensitivity)

Are you currently using topical retinoid prescriptions (Tretinoin / Retin-A / Renova / Differin / Tazorac / Avage / Epiduo / Ziana) Yes ___ No ___ what strength? _____ how long? _____ (Discontinue 5 days before and after treatment)

Are you currently using Accutane? Yes ___ No ___ for how long? _____ (Treatment must have been discontinued 6 months prior to receiving any skincare procedure)

Have you had a chemical peel or any type of skincare procedure with a medical device? Yes ___ No ___ within the last 14 days? Yes ___ No ___ what type? _____

Do you have regular collagen, Botox, or dermal filler injections? Yes ___ No ___ (peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

Have you recently had facial surgery? Yes ___ No ___ describe: _____

How long ago? _____

Have you recently had laser resurfacing? Yes ___ No ___ when? _____ what type? _____

Do you participate in regular vigorous activity or sports? Yes ___ No ___ what type? _____

Do you smoke or use tobacco? Yes ___ No ___

Do you develop cold sores / fever blisters? Yes ___ No ___ last breakout? _____

Are you allergic / sensitive to anything topical? Yes ___ No ___ what? _____

Are you sensitive to alcohol based products? Yes ___ No ___

Have you ever used products that gave you a bad reaction? Yes ___ No ___ describe _____

Are you taking any medication at this time? (antibiotics may increase sensitivity.) _____

What is your heredity background? _____

Natural eye color: blue ___ green ___ hazel ___ gray ___ lt. brown ___ med brown ___ dk brown ___

Natural hair color: blonde ___ red ___ lt. brown ___ med brown ___ dk brown ___ black ___ gray/silver ___ white ___

Skin tone: pale/white ___ light ___ medium ___ reddish ___ freckled ___ sallow ___ lt. olive ___ med olive ___ dark olive ___ lt. brown ___ med brown ___ dark brown ___ soft black ___ black ___

Do you consider your skin: sensitive ___ resilient ___ unsure ___

Describe your skin: (check all that apply) normal ___ dry ___ t-zone/combination ___ thick ___ thin ___ saggy ___ firm ___ small pores ___ large pores ___ rosacea ___ oily ___ acne ___ comedones/milia ___ cysts ___ breakouts ___ acne-scarred ___ eczema ___ freckled ___ sun-damaged ___ melasma ___ hyperpigmentation ___ uneven/blotchy ___ mature ___ wrinkled ___ patchy/dryness ___ sallow ___ psoriasis ___ hypopigmentation ___ dehydrated/lacking moisture ___ asphyxiated ___

talangiectasia/broken surface capillaries ___

How do you want to improve your skin? _____