Non-Surgical Cosmetic Consultation

Patient Information

If you do not understand any question, please ask for assistance.

Last name	First name	MI	Gender	Date of birth	Today's Date

Street address	Apt #	City	State	Zip

Home phone	Cell phone	Email address

What treatments are you interested in? *(Check all that apply.)*

Physician-Recommended, Prescription Strength Skin Care Products

- ☐ SkinCeuticals®
- ☐ OBAGI Nu-Derm®

Laser and Intense Pulse Light (IPL) Services

- ☐ Fractional Non-Ablative Skin Resurfacing
- ☐ Permanent Hair Reduction
- ☐ Photofacials
- ☐ Removal of Pigmented Lesions (Red/Brown)
- ☐ Removal of Vascular Lesions (Face)

Other Non-Surgical Cosmetic Services

- ☐ Microdermabrasion
- ☐ Botox® Injection
- ☐ Juvéderm® Injection
- ☐ Perlane® Injection
- ☐ Restylane® Injection

Skin Care Information

1.) What is your natural hair color? ______________________

2.) What is your eye color? ______________________

3.) Which best describes your skin type?

Skin Type	Skin Color	Tanning Response
☐ Type 1	White	Always burn, never tan.
☐ Type 2	White	Usually burn, difficult to tan.
☐ Type 3	White	Sometimes mild burn, average tan.
☐ Type 4	Brown	Rarely burn, tan with ease.
☐ Type 5	Dark Brown	Rarely burn, tan very easily.
☐ Type 6	Black	Very rarely burn, tan very easily.

4.) Describe your skin. *(Check all that apply.)*

- ☐ Normal
- ☐ Dry
- ☐ Patchy dryness
- ☐ Oily
- ☐ T-zone/combination
- ☐ Sensitive
- ☐ Thin
- ☐ Thick
- ☐ Firm
- ☐ Lax/Loose
- ☐ Uneven texture
- ☐ Wrinkles
- ☐ Sallow
- ☐ Mature
- ☐ Problem/Blemished
- ☐ Adolescent acne
- ☐ Adult onset acne
- ☐ Acne scars
- ☐ Breakouts
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Freckled
- ☐ Sun damaged
- ☐ Large pores
- ☐ Ingrown hairs
- ☐ Telangiectasia/broken capillaries
- ☐ Hypo-pigmentation
- ☐ Rosacea
- ☐ Eczema
- ☐ Other

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Skin Care Information (continued)

5.) What are the cosmetic improvements you would like to see in your skin? *(Check all that apply.)*

- ☐ Clear up breakouts
- ☐ Decrease oiliness
- ☐ Diminish excess flakiness
- ☐ Help clear up blackheads/whiteheads
- ☐ Help diminish fine lines/wrinkles
- ☐ Hydrate skin
- ☐ Lighten discoloration/hyper-pigmentation
- ☐ Lighten/soften acne scars
- ☐ Minimize pore size
- ☐ Restore elasticity
- ☐ Smooth skin texture
- ☐ Other: ______________________

6.) What body part(s) and/or area(s) do you want to improve:

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7.) Describe current daily skin care regimen: *(i.e. How much time do you spend on your daily skin care? What products do you use?)*

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8.) Check if applicable.

- ☐ Active infection/immunosuppressed
- ☐ Have permanent make-up, implants, and/or tattoos
- ☐ History of herpes I or II
- ☐ History of keloid or hypertrophic scar formation
- ☐ History of seizures
- ☐ Irregular menstrual periods
- ☐ Open lesion
- ☐ Pregnant
- ☐ Taken Accutane® and/or anticoagulants in past 6 months
- ☐ Unprotected sun exposure, used tanning bed or tanning creams in last 2-4 weeks
- ☐ Use of mechanical epilation (i.e. pluck, wax, tweeze, electrolysis or sugaring)
- ☐ Used tretinoin (Retin-A®, Renova®)

Medical History

9.) Please list ALL current medications, dosages and frequency.

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10.) Do any of these medications make your skin photo-sensitive?

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Medical History (continued)

11.) Please list ANY allergies.

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12.) Family Physician:______________________________ Phone: ______________

13.) Please list any current or chronic medical illnesses.

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14.) Emergency Contact:______________________________ Phone: ______________

Signature: ______________________________ *Date:* ______________

For Technician Use Only

Treatment/Procedure/Product Recommendation

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Estimate

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