



Non-Surgical Cosmetic Consultation

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				

Patient Information

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
<input type="checkbox"/> Type 1	White	Always burn, never tan.
<input type="checkbox"/> Type 2	White	Usually burn, difficult to tan.
<input type="checkbox"/> Type 3	White	Sometimes mild burn, average tan.
<input type="checkbox"/> Type 4	Brown	Rarely burn, tan with ease.
<input type="checkbox"/> Type 5	Dark Brown	Rarely burn, tan very easily.
<input type="checkbox"/> Type 6	Black	Very rarely burn, tan very easily.

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

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

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

- | | |
|--|---|
| <input type="checkbox"/> Clear up breakouts | <input type="checkbox"/> Lighten discoloration/hyper-pigmentation |
| <input type="checkbox"/> Decrease oiliness | <input type="checkbox"/> Lighten/soften acne scars |
| <input type="checkbox"/> Diminish excess flakiness | <input type="checkbox"/> Minimize pore size |
| <input type="checkbox"/> Help clear up blackheads/whiteheads | <input type="checkbox"/> Restore elasticity |
| <input type="checkbox"/> Help diminish fine lines/wrinkles | <input type="checkbox"/> Smooth skin texture |
| <input type="checkbox"/> Hydrate skin | <input type="checkbox"/> Other: _____ |

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

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?)*

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®)

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

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



Medical History (continued)

11.) Please list ANY allergies.

Horizontal lines for listing allergies.

12.) Family Physician: _____ Phone: _____

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

Horizontal lines for listing medical illnesses.

14.) Emergency Contact: _____ Phone: _____

Signature: _____

Date: _____

For Technician Use Only

Treatment/Procedure/Product Recommendation

Horizontal lines for treatment recommendations.

Estimate

Horizontal lines for estimate details.

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