PATIENT INFORMATION SHEET

NAME: _____ **DATE:** _____

ADDRESS: _____

DOB: _____ **HOME PHONE** _____ **CELL PHONE:** _____

EMAIL: _____ **IS IT OKAY LEAVE MESSAGES ON YOUR HOME PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER** _____

RELATION: _____ **PHARMACY & LOCATION:** _____

PLEASE LIST ALL ALLERGIES TO MEDICATIONS OR PRODUCTS such as Aspirin or Sulfur: _____

DO YOU CURRENTLY SEE A DERMATOLOGIST? If yes, who? _____

RECENT SURGERIES: _____

HOW DID YOU HEAR ABOUT US? _____

PLEASE CHECK ALL THAT APPLY:

- ☐ SKIN CANCER
- ☐ LUPUS OR OTHER AUTO IMMUNE DEF
- ☐ HIV
- ☐ HEPATITIS
- ☐ BLEEDING ABNORMALITIES
- ☐ BLOOD THINNING MEDICATION
- ☐ ACCUTUNE IN THE PAST 6 MONTHS
- ☐ KELOID OR THICK SCARRING
- ☐ CYSTIC ACNE
- ☐ DIABETES
- ☐ HIRSUTISM
- ☐ TRANSPLANT ANTI REJECTION DRUGS
- ☐ PREGNANT
- ☐ PSORIASIS
- ☐ VITILIGO
- ☐ HERPES SIMPLEX OR FEVER BLISTERS
- ☐ CHEMICAL PEELS
- ☐ MICRODERMABRASION
- ☐ WAXING OR PLUCKING
- ☐ ELECTROLYSIS IN THE PAST 4 WEEKS
- ☐ LASER RESURFACING
- ☐ FACIAL PLASTIC SURGERY
- ☐ SILKPEEL
- ☐ REJUVAPEN
- ☐ HYDRAFACIAL

HOW DO YOU DESCRIBE YOUR SKIN:

○ VERY DRY ○ NORMAL COMBO ○ OILY ○ ACNE PRONE ○ SENSITIVE ○ ROSACEA

DO YOU USE SUNSCREEN AND HOW OFTEN: _____

DO YOU USE:

☐ RETIN-A ☐ RETINOL ☐ VITAMIN C SERUMS ☐ HYALURONIC ACIDS ☐ TAZORAC ☐ FINACEA or METROGEL

TO HELP US BETTER UNDERSTAND YOUR NEEDS PLEASE SELECT THE TREATMENTS AND OR PROCEDURES THAT YOU WOULD LIKE TO KNOW MORE ABOUT:

- ☐ ACNE TREATMENT
- ☐ LIP ENHANCEMENT
- ☐ BROWN SPOTS
- ☐ ACTINIC KERATOSIS
- ☐ SKIN CARE PRODUCTS
- ☐ BOTOX
- ☐ SKIN REJUVENATION
- ☐ FACIAL VASCULAR VEINS
- ☐ MILLA EXTRACTIONS
- ☐ SUN SPOT
- ☐ DERMAFILLERS
- ☐ COLLAGEN FOR WRINKLES
- ☐ HAIR REDUCTION
- ☐ FACELIFT/NECK-LIFT
- ☐ BAGS UNDER EYES
- ☐ SCULPTRA
- ☐ FACIAL REDNESS/ROSACEA
- ☐ SEBORRHEIC KERATOSIS
- ☐ EYEBROW LIFT
- ☐ UPPER/LOWER BELPH