



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:

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

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:

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