Welcome to Affiliated Dermatologists, S.C. Skin and Laser Center!

INITIAL CONSULTATION

Name _____ Date _____
Referring Physician _____

In order to provide you with the most appropriate skin renewal treatment, we would appreciate your time in completing the following information:

AREAS OF INTEREST:

- □ Laser Hair Removal/Area _____
- □ Microdermabrasion/Chemical Peels
- □ Photo Rejuvenation
- □ Collagen Induction Therapy
- □ Fractional CO2 Laser Resurfacing
- □ Products
- □ Make-Up

SKIN ASSESSMENT - CHECK ALL THAT APPLY:

- □ Sun Damage
- □ Brown Spots
- □ Upper Lip Lines: □ Deep □ Fine
- □ Freckles
- □ Wrinkles: □ Deep □ Fine
- □ Blackheads □ Whiteheads
- □ Hard Bumps Under Skin
- □ Milia
- □ Clogged/Enlarged Pores
- □ Excessive Oiliness
- □ Acne
- □ Pimples: □ Often □ Sometimes
- □ Dry Patches
- □ Visible Broken Blood Vessels

Type of Skin:

- □ Dry □ Normal/Combination
- □ Oily

SKIN CARE REGIME:

Please check the products you are currently using and list the **Brand Names:**

- □ Cleanser _____
- □ Moisturizer _____
- □ Toner _____
- □ Scrub _____
- □ Eye Cream _____
- □ Night Cream _____
- □ Sunscreen _____
- □ RX Topicals _____
- □ Other _____

SKIN TYPE:

Which of the following best describes your skin type?

- □ I - Always burns, never tans
- □ II - Always burns, sometimes tans
- □ III - Sometimes burns, sometimes tans
- □ IV - Always tans
- □ V - Hispanic, Asian, Mediterranean, Middle Eastern
- □ VI - Black

Ethnicity:

□ Mediterranean □ Middle Eastern □ African American □ Native American
□ French □ German □ English □ Greek
□ Irish □ Italian □ Asian □ Hispanic
□ Scandinavian □ Other _____

MEDICAL HISTORY:

Do you have any of the following?

□ Diabetes
□ Thyroid
□ Immune Deficiency
□ Lupus
□ Currently undergoing Chemotherapy
□ High Blood Pressure
□ Pacemaker/Defibrillator
□ Heart Murmur
□ Heart Attack
□ Kidney Disease
□ Bleeding Disorder
□ Phlebitis
□ HIV
□ Hepatitis
□ Polycystic Ovarian Syndrome
□ Hormone Issues
□ Asthma
□ Tuberculosis
□ Smoker - If so, how long? ___
□ Seizures
□ Skin Cancer
□ Melanoma
□ Flat warts/moles
□ Keloid scarring
□ Pigmentation Disorder
□ Accutane w/in 12 mo.
□ Cold sores
□ Permanent makeup/ tattoos
□ Pregnant? Nursing?

Other Medical Conditions - Please explain _____

_____

_____

DRUG ALLERGIES: _____

_____

OTHER ALLERGIES: _____

CURRENT MEDICATIONS - including over-the-counter, herbal, or natural supplements:

_____

_____

_____

_____ _____

Patient Signature Date

FOR TECHNICIAN USE

NOTES: _____

_____

_____

_____

_____

_____

_____

RECOMMENDATIONS: _____

_____

SAMPLES GIVEN: _____

_____

Staff: _____