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
- □ Dermaplaning
- □ Chemical Peels
- □ Extractions
- □ Collagen Induction Therapy/ Micro-needling
- □ Photo Rejuvenation/ IPL
- □ 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 _____
- □ Toner _____
- □ Serum _____
- □ Moisturizer _____
- □ Scrub _____
- □ Eye Cream _____
- □ Night Cream _____
- □ Sunscreen _____
- □ RX Topical _____
- □ 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
□ Keloid scarring
□ Pigmentation Disorder
□ Accutane w/in 12 mo.
□ Cold sores Date of last_____
□ 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: _____