

Consultation Card

Name _____ DOB _____ Age _____
Last First Middle

Address _____
Street City State Zip

Phone # (____) _____ Work # (____) _____ Cell # (____) _____

Occupation _____ Email _____

Referred by _____ Primary Physician _____

General Health Information

Are you currently under physicians care? Yes No Any surgery in the past 12 months? Yes No

Present medications _____

Allergies _____ Do you take vitamins? Yes No

Do you or any family members have any history of: Heart problems High blood pressure Diabetes Cancer
 Thyroid Excessive bleeding or scarring Epilepsy Other

Past/Present illnesses _____

Skin Analysis

How would you best describe your skin? oily normal to oily normal normal to dry dry

Have you ever had a facial? Yes No Have you ever had a chemical peel? Yes No type _____

What type of products do you currently use? cleanser moisturizer toner sunscreen creams & serums

Do you use Retin A, Renova, Alpha hydroxy or Glycolic? Yes No

Have you been in the sun, tanning bed, or using self-tanners? Yes No If so, when? _____

Are you or have you ever used Accutane? Yes No If so, when? _____ how long? _____

Have you had any of following in the past or present? Botox Last treatment _____
 Collagen/Restalyne Last treatment _____
 Waxing Area & when? _____
 Electrolysis Area & when? _____
 Laser treatments Last treatment _____

What services and treatments are you interested in? _____

Signature _____ Date _____