Skin Care Consultation Card

DATE OF 1st VISIT ________________ AGE __________ REFERRED BY _________________________

NAME ____

LAST MIDDLE FIRST

ADDRESS ____

PHONE ____

Medications

Allergies ____

Medications ____

- Do you follow any special diet? Yes ___ No ___
- Are you pregnant? Yes ___ No ___
- Breastfeeding? Yes ___ No ___
- Do you smoke? Yes ___ No ___
- Do you wear contact lenses? Yes ___ No ___
- Any skin problems? Yes ___ No ___
- Any skin cancer? Yes ___ No ___
- Any recent surgery? Yes ___ No ___
- Any pins or metallic implants? Yes ___ No ___
  If yes, explain: _________________________________
- Have you had laser treatments? Yes ___ No ___
- Have you ever had collagen fillers? Yes ___ No ___

- Do you use Retin A? Yes ___ No ___
  Acne? __ Cosmetic? __ Last date used? __ Strength? ___
- Do you use Accutane? Yes ___ No ___
  Have you used Accutane in the past? Yes ___ No ___
  Dosage/Duration ________________
- Herpes Simplex/Cold Sores? Yes ___ No ___
  If yes, last eruption? _____________
- On the pill? Yes ___ No ___
  If yes, since when? ______________
- Hormones? Yes ___ No ___
  If yes, how much? ______ How long? _______________
- Seen Dermatologist? Yes ___ No ___
  Who? _________When? _______ Treatment? _________

General Skin Care Information

1. How do you cleanse your face? Soap? __ Brand _________________ Cleanser? __ Brand ___________________
2. Do you use any home treatment products? Yes ___ No ___ If yes, what brand? _____________________________
3. Are you using any products that contain alpha hydroxy acids? Yes ___ No ___
   If yes, what brand? ________________________
4. Do you feel any burning or itching on the skin? If yes, specify areas _____________________________________
5. Have you ever had a skin treatment before? Yes ___ No ___ If yes, when was your last treatment? ___________
6. What is the purpose of your visit? ____
7. What kind of improvement would you like to see on your skin? ____

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NOTES: ____

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Signature: ____