

Skin Consultation Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_Zip: \_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single: ☐no ☐yes Married: ☐no ☐yes If yes, anniversary date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Diabetes Epilepsy Heart Disease Pacemaker Hemophiliac

Pregnant Virus Cortisone Circulatory Disorder I.U.D.

Anticoagulants Hypertension Hormonal Treatment Glandular Disorder Metallic Implants

**Skin Disease:**

Are you pregnant or lactating? Yes No Are you prone to herpes outbreaks? Yes No

Please list all medications you are taking internally, including Accutane (and when last taken):

Please list any medications that you regularly use topically, include Retin-A, AHA’s:

Please list any allergies or allergic reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much sun exposure to you receive? A lot Average Minimal

Do you suffer from any of the following?

Milia Acne (where): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rosacea Psoriasis

Age Spots Hyerpigmentaton Hypopigmentation Moles

Warts Broken Capillaries Eczema

Have you ever experienced the following? In the last month? No Yes

Professional Peels

Glycolic Peels

Salicylic Peels

Waxing (where):\_\_\_\_\_\_\_\_\_\_

TCA Peels

Medical Dermabrasion

Jessner’s Peels

Laser Hair Removal

Microdermabrasion

What would you like to achieve from your treatment today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your skin care**

Which of the following best describes your skin type? (Please circle one type number)

1 creamy complexion always burns easily, never tans

II light complexion always burns, tans slightly

III light/matte complexion burns moderately, tans gradually

Iv matte complexion seldom burns, always tans well

V brown complexion rarely burns, deep tan

Vi black complexion never burns, deeply pigmented

What skin care products are you currently using? (LIST BRAND WHERE KNOWN)

Soap ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shower Gels\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lotions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mask \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sunscreen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cleanser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Night Moisturizer/Cleanser\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Moisturizer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exfoliator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Makeup Products\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scrubs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What areas of concern do you have regarding your: **Skin:** (Please check any that apply & explain)

☐ Breakouts/acne

☐ Broken Capillaries ☐ Blackheads/whiteheads ☐ Sun Damage ☐ Excessive Oil/ shine ☐ Wrinkles/fine lines ☐ Rosacea

☐ Flaky Skin

☐ Redness ☐ Dehydrated ☐ Sun spot/brown spot

☐ Dull/dry skin ☐ Uneven skin tone ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other areas of concern that you would wish to discuss with Dr. Capuano during your initial consultation? If so, please describe your interest or concern(s) below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you enrolled in a Section 125 Health Savings Account (HAS), Flexible spending Account (FSA) or Health Reimbursement Account (HRA)? Yes No

I hereby certify to the best of my knowledge that the answers I have given are correct. I also do not have any medical condition(s) or received advice from my medical provider that would prevent me from receiving the treatments I have selected. Furthermore, I agree to hold harmless Northern Center For Plastic Surgery from any and all liability relating to any injury that may sustain as a result of having the aforementioned medical condition(s).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_