



**SKIN CARE CONSULTATION FORM**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Welcome to Adult & Pediatric Dermatology, pc cosmetic skin care program. We ask that you take a few moments to fill out this questionnaire so that we may better classify your skin problems and skin type.

How did you hear about us? \_\_\_\_\_

What skin problems concern you?

- Acne
- Blackheads
- Wrinkles  
Location \_\_\_\_\_
- Dry Skin  
Location \_\_\_\_\_
- Textural Changes  
Location \_\_\_\_\_
- Brown Discoloration  
Location \_\_\_\_\_
- Red Discoloration  
Location \_\_\_\_\_
- Skin Lesions or Spots  
Location \_\_\_\_\_
- Unwanted Hair  
Location \_\_\_\_\_

Are you currently under a Dermatologist's care \_\_\_\_yes \_\_\_\_no

Reason for Dermatologist \_\_\_\_\_

How do you currently care for you skin?

In the morning:

- \_\_ You wash with: \_\_\_\_\_
- \_\_ Use a toner or astringent: \_\_\_\_\_
- \_\_ Apply a moisturizer: \_\_\_\_\_
- \_\_ Apply a sunscreen: \_\_\_\_\_
- \_\_ Apply any topical prescribed therapies: \_\_\_\_\_
- \_\_ Apply foundation, make up: \_\_\_\_\_

In the evening:

- \_\_ You wash with: \_\_\_\_\_
- \_\_ Use a toner or astringent: \_\_\_\_\_
- \_\_ Apply a moisturizer: \_\_\_\_\_
- \_\_ Apply any topical prescribed therapies: \_\_\_\_\_

Products Used:

- \_\_ Retin A
- \_\_ Salicylic
- \_\_ Alpha or Beta Hydroxy Products
- \_\_ Accutane

<p><b>ESTHETIC NOTES:</b> Fitzpatrick skin type:</p>          
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**SKIN/SUN HISTORY:**

What is your natural eye color? \_\_\_\_\_ What is your natural hair color? \_\_\_\_\_

Ethnicity? \_\_\_\_\_

Do you spend time in the sun  yes  no If yes, how much? \_\_\_\_\_

Sunblock use  yes  no what SPF \_\_\_\_\_

Self-tanning lotion  yes  no

Have you ever had any skin cancer or precancerous skin lesions removed? If so where? \_\_\_\_\_

When exposed to 30 minutes of mid-day summer sun, does your skin:

- Always burn  Usually tans, occasionally burns  
 Burn, then tan  Always tans

**HEALTH HISTORY**

Are there any health problems that we should be aware of?

Are you presently on any oral medications? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

Do you wear contact lenses?  yes  no

Have you ever had any cold sore infections?  yes  no

Do you exercise?  yes  no Type of exercise: \_\_\_\_\_

**TREATMENT HISTORY**

Have you ever been treated with a deep peel or dermabrasion?  yes  no

Have you ever had light peels, facials, or other skin treatments?  yes  no

Have you ever had cosmetic surgery?  yes  no

Do you use skin lighteners?  yes  no

Do you use any acne medication?  yes  no

**SOCIAL HISTORY**

Do you smoke?  yes  no

Do you drink alcohol?  yes  no

**GYN HISTORY**

Date of last menses? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Are you breastfeeding? \_\_\_\_\_

Are you planning to become pregnant in the next several months? \_\_\_\_\_

Are you using birth control pills?  yes  no

Hormone replacement?  yes  no

At Adult & Pediatric Dermatology, pc, we wish to educate you about the four levels of treatment available to give your skin a more youthful appearance. We hope to design a treatment plan specifically for you. We believe in utilizing the most conservative treatment plan that will best achieve your treatment goals.

Please review our "Cosmetic Service" brochure for information about therapies that are available to our patients. After reviewing this information, what specific services would you like more information on? \_\_\_\_\_