

*Skin & Cosmetic Solutions*  
**Raleigh Dermatology**  
*Skin Rejuvenation & Aesthetic Services*

Client Profile

In order to provide you with the highest quality care please complete the following information..

**PATIENT INFORMATION:** \*\*\* Thank you for including your middle name! E-MAIL ADDRESS: \_\_\_\_\_

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

Name (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) \_\_\_\_\_

Address: \_\_\_\_\_ (Please include apartment number)

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Birth Date: (month, day, and year) \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Please check all that apply.

Referred by:  My Doctor, whose name is: \_\_\_\_\_

Raleigh Dermatology: (Name of Doctor) \_\_\_\_\_

(Name of Nurse) \_\_\_\_\_ (Physician's Assistant) \_\_\_\_\_

Newspaper: (check one) \_\_\_\_\_ News and Observer \_\_\_\_\_ Carolina Woman \_\_\_\_\_ Other \_\_\_\_\_

Friend or family member, whose name is: \_\_\_\_\_

TV  Yellow Pages (check one) \_\_\_\_\_ Plastic Surgery section \_\_\_\_\_ Dermatology section  Talking Phone Book  Saw

Location  Internet /Website

Seminar/ the event was: \_\_\_\_\_

Other (please specify) \_\_\_\_\_

**PROCEDURES OF INTEREST TO YOU :** (please check)

Skin Care Advice/Products  Collagen Injections/Implants and Botox  Liposuction

Endermologie  Laser Treatment (please check) \_\_\_\_\_ tattoos \_\_\_\_\_ birthmarks, \_\_\_\_\_ facial veins, \_\_\_\_\_ age spots

Spider Vein Therapy  Chemical Peels/Dermabrasion  Laser Hair Removal  Other? \_\_\_\_\_

**MEDICAL:** Are you currently or within the last year under ANY doctor's care?  NO  YES

Explain: \_\_\_\_\_

**Health Problems:** (Please circle) Diabetes, Thyroid, Heart, Cancer, Hysterectomy, Hormone Imbalance, Epilepsy,

Other \_\_\_\_\_

**Medications, Drugs, and Vitamins:** (List all and why?) \_\_\_\_\_

Glycolic Products  Retinol  Renova  Retin-A  Accutane  Diet Tablets  Smoke  Stimulants  Laxatives

Diuretics  Oral Contraceptives  Other?

Have you undergone any surgery?  No  Yes? Explain: \_\_\_\_\_

Do you have any metal implants?  No  Yes? Explain: \_\_\_\_\_

Do you sleep adequately and exercise regularly?  No  Yes? Explain: \_\_\_\_\_

**SKIN CARE REGIMEN/CONDITION:**

Skin care concern or problem \_\_\_\_\_

What is your daily consumption of Water? \_\_\_\_\_ Oz. Coffee \_\_\_\_\_ Oz Tea \_\_\_\_\_ Oz. Soft Drinks(Diet/Reg.) \_\_\_\_\_ Oz.

Other \_\_\_\_\_

What water temperature do you cleanse with?  cold  warm  hot

What is your skin condition?  dry  oily  unremarkable

Special skin problems?  flaking  tightness  other

Personal skin care now?  soap  cleanser  toner  scrub  masque

moisturizer  other

Sunburn  No  Yes #SPF \_\_\_\_\_

Massage Preference  Heavy  Light

Do you ever experience skin break-outs?  No  Yes

Have you had a reaction to a treatment?  No  Yes

Does PABA affect you in any way?  No  Yes

Sinus Problems?  No  Yes

Do you blush easily?  No  Yes

Redness tendency?  No  Yes

**FEMALE CLIENTS ONLY:** Are you pregnant or trying to be?  No  Yes Are you taking oral contraceptives?  No  Yes