

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:

Date: _____ Birth Date: (month, day, year): _____

Name (first) _____ (middle initial) _____ (last) _____

Address: _____

(please include apt. number) _____

City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-MAIL ADDRESS: _____

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 _____ Other _____
☐ Friend or family member, whose name is: _____
☐ TV ☐ Yellow Pages (check one) _____ Plastic Surgery section _____ Dermatology section ☐ Saw Location
☐ Internet /Website ☐ Facebook
☐ Seminar/ the event was: _____
☐ Other (please specify) _____

PROCEDURES OF INTEREST TO YOU: (please check)

- ☐ Skin Care Advice/Products ☐ Facial Injections and Botox ☐ Liposuction ☐ Fraxel Treatment
☐ Endermologie ☐ Laser Treatment (please check) _____ tattoos _____ birthmarks, _____ facial veins, _____ age spots, _____ tightening
☐ 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 ☐ combination

Special skin problems? ☐ flaking ☐ tightness ☐ other

Personal skin care now? ☐ soap ☐ cleanser ☐ toner ☐ scrub ☐ masque

☐ moisturizer ☐ other _____

Sunburn ☐ No ☐ Yes #SPF _____

Do you ever experience skin break-outs? ☐ No ☐ Yes

Have you had a reaction to a treatment? ☐ No ☐ Yes

Sinus Problems? ☐ No ☐ Yes

Do you blush easily? ☐ No ☐ Yes

Redness tendency? ☐ No ☐ Yes

Massage Preference ☐ Heavy ☐ Light

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