

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