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