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