

Consultation

***Patient to fill out: Please checkbox or fill in the blank.

CURRENT SIGNS AND SYMPTOMS

1. I am consulting for:
 Symptomatic reasons Cosmetic reasons Both

2. I have problems with my? Face Neck Chest
 Back Other _____

3. Please checkbox the signs & symptoms you are experiencing:
 Pain Heat / burning Ocular changes
 Itching Skin thickening Enlarged nose
 Flushing Spider Veins other _____
 Redness Skin discoloration _____
 Swelling Acne (papules/pustules) _____

4. Easy irritation with common skin care products? Y N
 5. How many years have you noticed this problem? _____
 6. Have your symptoms gotten worse recently? Y N

AGGRAVATING FACTORS

Please checkbox things that aggravate your symptoms:
 Temperature changes
 Exercise Alcohol Stress
 Foods (please list) _____
 Medications (please list) _____
 Other _____

PREVIOUS TREATMENTS / PROCEDURES

Y or N

Have you taken **oral** meds or antibiotics for your skin condition (list) _____ How long? _____
 Did they work? Y N Are you currently taking? Y N

Have you been placed on **topical** meds for your skin condition (list) _____ How long? _____
 Did they work? Y N Are you currently taking? Y N

Other _____

PERTINENT PAST MEDICAL HISTORY

Y or N

Pregnancy / Breastfeeding / Trying to conceive
 Easy bruising / bleeding _____
 History of cold sores _____
 Accutane or accutane-like products within 6 months
 Impaired healing
 Suntanned skin (within the last 3 weeks)
 History of keloid scarring
 Atypical (unusual) moles
 History of skin cancer, psoriasis, eczema, _____

Photoallergic / Photosensitive (i.e. Lupus or Porphyria)
 Dermatologic conditions (i.e., sores, psoriasis, eczema, infection, rash) _____

Other: _____

SKIN TYPING

What is your ethnic background? (i.e., Irish, Italian, Indian, Asian, Hispanic, African American, etc.) _____

Please checkbox the skin type that describes you the best when you are exposed to the sun for 2 hours without sunblock.

Type I: Always burn, Never tan
 Type II: Always burn, Sometimes tan
 Type III: Sometimes burn, Always tan
 Type IV: Never Burn, Always tan
 Type V: Moderately pigmented (Hispanic, Asian)
 Type VI: Black

SPECIFIC MEDICATION QUESTIONS

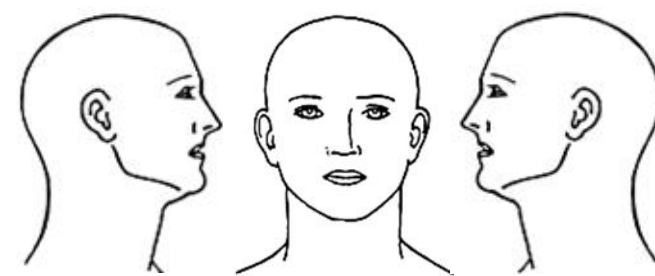
Y or N

Are you on birth control? _____
 Are you on hormone replacement? _____

Other _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

*****FOR OFFICE USE ONLY*****

<p>Right Center Left</p>  <p>List treatment areas other than face _____</p>	<p><input type="checkbox"/> Photos Taken</p> <p>ASSESSMENT</p> <p><input type="checkbox"/> Rosacea <input type="checkbox"/> Telangiectasia <input type="checkbox"/> Port Wine Stain <input type="checkbox"/> Poikiloderma <input type="checkbox"/> Solar Lentigo <input type="checkbox"/> Melasma <input type="checkbox"/> Hemosiderin Staining <input type="checkbox"/> Hemangioma <input type="checkbox"/> Hyperpigmentation Other _____</p> <p>PLAN</p> <p><input type="checkbox"/> IPL <input type="checkbox"/> Topical meds _____ <input type="checkbox"/> Oral meds _____ Other _____</p> <p>Notes:</p>
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