



NAME _____ TODAYS DATE _____

DATE OF BIRTH _____ OCCUPATION _____

HOME ADDRESS _____ CITY _____ ZIPCODE _____

HOME PHONE () _____ CELL PHONE () _____

WORK PHONE () _____ E-MAIL ADDRESS _____

Can we call to confirm your appointment? Yes / No Best time _____

How did you hear about us? _____

Reason for your consultation? (Cosmetic interest and expectations) _____

Have you been treated by a dermatologist? Yes / No What was/is condition? _____

Please list your past cosmetic procedures: _____

List all Allergies to medications or substances: _____

List all medications, herbs, vitamins or OTC preparations you are currently taking or applying:

Are you pregnant? _____ Planning pregnancy? _____ Nursing? _____

Do you smoke? _____ Do you wear sun block? _____

Please check all that apply to you:

____ Anemia ____ Colitis ____ Hepatitis ____ Low blood pressure ____ Thyroid condition

____ Arthritis ____ Cold sores/Herpes ____ High blood pressure ____ Migraine Headaches ____ Ulcer

____ Asthma ____ Diabetes ____ Hormone imbalance ____ Psoriasis ____ Varicose Veins

____ Cancer ____ Eczema ____ Insomnia ____ Seborrhea ____ Other

____ Chronic Fatigue ____ Heart Problems ____ Keloid Scars ____ Systemic Disease

If you checked any of the above, please explain: _____

Signature: _____ Date: _____