



Cosmetic Consultation and Analysis

Name:

Age:

Date:

Email:

Contact Phone Number:

How did you hear about us?

We offer many aesthetic services, products, and procedures. If you would like more information, please check the box of all that you are interested in.

- | | | |
|---|---|--|
| <input type="checkbox"/> Botox Cosmetic | <input type="checkbox"/> Skin Care Advice | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Fine lines and wrinkles | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Lips |
| <input type="checkbox"/> Skin Rejuvenation | <input type="checkbox"/> Spider Vein Treatments | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Treatment for Scars | <input type="checkbox"/> Liver Spots / Age Spots | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Facials and Eye Treatments | <input type="checkbox"/> Sunscreen Advice | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Laser Resurfacing (Fraxel) | <input type="checkbox"/> Removing Leg Veins | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Fillers (Restylane, Juvederm, Sculptra, Perlane) | |
| <input type="checkbox"/> Other, please specify: _____ | | |

- | | | | | |
|------------------------------|-------------------------------------|---|--|---|
| Pore Size: | <input type="checkbox"/> Small | <input type="checkbox"/> Medium | <input type="checkbox"/> Medium Large | <input type="checkbox"/> Large |
| Appearance: | <input type="checkbox"/> Dull | <input type="checkbox"/> Glow on Nose | <input type="checkbox"/> T-Zone Shine | <input type="checkbox"/> All-over Shine |
| Breakouts: | <input type="checkbox"/> Never | <input type="checkbox"/> Once per Month | <input type="checkbox"/> 1 - 2 / Month | <input type="checkbox"/> More |
| Untreated Skin Feels: | <input type="checkbox"/> Dry, Tight | <input type="checkbox"/> Slightly Dry | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Oily |
| Skin Type: | <input type="checkbox"/> Dry | <input type="checkbox"/> Normal - Dry | <input type="checkbox"/> Normal - Oily | <input type="checkbox"/> Oily |
| Sensitivity: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never | |

Current Skin Care Program: (List the products currently used)

| AM | PM | Occasionally (Masks, etc.) |
|-------|-------|----------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Your Response To Tanning (circle one):

- | | |
|--|--|
| 1. Always burns, never tans | 4. Rarely burns, tans with ease |
| 2. Usually burns, tans with difficulty | 5. Very rarely burns, tans very easily |
| 3. Sometimes mild burn, tans average | 6. No burns, tans very easily |

Medical History

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Smoking | <input type="checkbox"/> HIV / Hepatitis | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Cold Sores / Fever Blisters |
| <input type="checkbox"/> Waxing / electrolysis | <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Problems Healing | <input type="checkbox"/> Keloids / Raised Scars |
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Other: | | |
| <input type="checkbox"/> Reactions to skin care products: | | | |
| <input type="checkbox"/> Plastic surgery (list) | | | |
| <input type="checkbox"/> Skin cancer (list) | | | |

Medications: _____

Office Notes / Treatment Plan:

Skin Type: 1 2 3 4 5 6

Photoaging Type: I II III IV