CONSULTATION FORM

NAME:_____ DOB:_____

ADDRESS:_____

E-MAIL ADDRESS:_____ PHONE: _____

WHAT IS YOUR PREFERRED METHOD OF CONTACT? E-MAIL ___ PHONE ___
IF YOU SELECTED PHONE, WHAT IS YOUR PREFERRED TIME OF DAY TO BE CONTACTED? A.M. __P.M.__
IF YOU SELECTED PHONE, CAN WE LEAVE A VOICEMAIL? YES ___ NO ___

ARE YOU PREGNANT? YES_____ NO_____

PLEASE LIST PAST OR PRESENT MEDICAL CONDITIONS/ILLNESSES, ALLERGIES:
_____

PRESENT MEDICATIONS/HERBAL SUPPLEMENTS (ACCUTANE, ANTIBIOTICS, ASPIRIN, ANTIVIRALS, BIRTH CONTROL, COUMADIN, DRUGS WHICH MAY CAUSE PHOTOSENSITIVITY)
LIST ALL MEDICATIONS:

_____

_____

PLEASE LIST ANY TOPICAL MEDICATIONS YOU ARE USING:_____

PLEASE LIST ANY DAILY SKIN CARE PRODUCTS YOU ARE CURRENTLY USING:

_____

DO YOU HAVE A HISTORY OF COLD SORES: YES_____ NO_____

DO YOU HAVE ANY IMPLANTS/INJECTBLES/ PERMANENT MAKE-UP/TATOOS? YES_____ NO_____

IF YES, PLEASE LIST AREA_____

DO YOU GO TANNING (SUN OR TANNING BED)? YES_____ NO_____ DO YOU USE SELF TANNERS?
YES_____ NO_____ DATES LAST USED_____

WHAT ARE THE COSMETIC IMPROVEMENTS YOU WOULD LIKE TO SEE?

_____

_____

PATIENT SIGNATURE_____ DATE_____