CARILION CLINIC
COSMETIC CENTER

Patient Information

Today's Date ____/____/_____ MRN# _____

Last Name **First Name** **Middle Initial**

Marital Status	Age	**Date of Birth** ____/____/_____
Address		
City	State	Zip Code
Home Phone ( )	Mobile ( )	Work ( )
Email Address	Preferred phone for text reminders:	
Would you like to receive appointment reminders and promotions? Text Only ☐ Email Only ☐ Text and Email ☐		
Occupation:	Employer:	

How did you hear about us?

Medical Health History

Reason for visit:

Have you had plastic surgery before? ☐ yes ☐ no

If yes, type of surgery and when:

Please list nutritional supplements and medications you are currently taking including hormone replacement therapy and birth control pills: ☐

Are you presently under a physician's care? ☐ yes ☐ no If yes, why?

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise? ☐ yes ☐ no

Smoker ☐ Date quit smoking: Never smoked ☐

Other nicotine products used:

Do you drink alcohol? ☐ yes ☐ no If yes, type and how often:

Have you ever used Accutane? ☐ yes ☐ no If yes when?

Please check the following conditions you have currently or have experienced in the past:

Abnormal Bleeding ☐	Frequent Headaches ☐	Seizures ☐
Anemia ☐	Heart Disease ☐	Stroke ☐
Asthma or COPD ☐	Hepatitis ☐	Thyroid disorder ☐
Cancer ☐	High Blood Pressure ☐	
Diabetes ☐	High Cholesterol ☐	

Other condition(s) not listed:

Allergies/sensitivities:

Latex	☐ yes	☐ no	
Lidocaine	☐ yes	☐ no	
Prescription drug	☐ yes	☐ no	Name of drug:
Anesthesia	☐ yes	☐ no	

Other allergies/sensitivities not listed:

Previous surgeries:

Date	Type of surgery	Surgeon / Facility

SURGICAL CONSULTS CONTINUE ON TO SIGNATURE LINE ON PAGE #3

Skin Care History

Have you seen a Dermatologist in the past year? ☐ yes ☐ no

If yes, list Dermatologist's name and reason for visit:

Please list any skin treatment(s) you are currently having:

Please check if you are presently using or have used in the past any of the following:

☐ Hydrocortisone	☐ Benzoyl Peroxide	☐ Vitamin A	☐ Resorcinol
☐ Hydroquinone	☐ Glycolic Acid (AHA)	☐ Vitamin C	☐ Salicylic Acid (BHA) Sulfur
	☐ Lactic Acid (AHA)		

Please check if you have had any of the following in the last 14 days:

☐ Waxing	☐ Facial Cosmetic Surgery	☐ Permanent Cosmetics	☐ Microdermabrasion
☐ Laser Hair Removal	☐ Botox Injections		☐ Light Treatments
	☐ Collagen Injections		☐ Laser Resurfacing
	☐ Dermal Fillers		☐ Chemical Exfoliation (Peel)

Please check if you are presently using or have used in the past any of the following **prescriptions:**

☐ Tretinoin (Retin A, Retin -A Micro, Renova, Avita)	☐ Tazarotene (Tazorac)	☐ Triluma
	☐ Isotretinoin (Accutane)	☐ Metrogel
	☐ Adepalene (Differin)	☐ Azelaic Acid (Azelex, Finacea)

Any other topical antibiotic:

Please check if you presently have or have had in the past any of the following**:**

☐ Skin Cancer	☐ Acne	☐ Treatment Reaction
☐ Dermatitis	☐ Rosacea	☐ Hypopigmentation (skin lightening)
☐ Keloid Scarring	☐ Broken Capillaries	☐ Hyperpigmentation (skin darkening)
☐ Herpes Simplex or Cold Sores		

Skin allergies/sensitivities:

Hydroquinone or skin bleaching agents ☐ yes ☐ no

Hydrocortisone ☐ yes ☐ no

Other skin allergies/sensitivities not listed:

Sun Protection

Do you use sunscreen? ☐ yes ☐ no

Do you sunbathe? ☐ yes ☐ no

Have you tanned in a tanning booth in the last 14 days? ☐ yes ☐ no

Have you had any direct sun exposure in the last 14 days? ☐ yes ☐ no

Have you recently used any self-tanning lotions or treatments? ☐ yes ☐ no

When exposed to the sun do you:

Always burn, never tan ☐	Always burn, sometimes tan ☐	Sometimes burn, sometimes tan ☐	Always tan ☐

Do you feel your skin is sensitive? ☐ yes ☐ no

Do you tend to scar easily or form raised scars (keloids)? ☐ yes ☐ no

Hair Removal/Laser Treatment History

Have you ever had laser hair removal? ☐ yes ☐ no

Please check any of the following hair removal methods used in the past six weeks:

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Stringing ☐ Depilatories

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ yes ☐ no

If yes, please describe:

Please list any other necessary information your skin specialist should know before beginning your treatment:

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment as well as use of home care products as directed to achieve the results desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I agree to inform the provider/staff of ANY changes pertaining to the above questionnaire prior to any future treatments. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician, nurse or doctor of my current medical or health condition and to update this history now and in the future. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that payment is due at time of all services and products. There are NO REFUNDS on any services.

Client Signature: **Date:**