



Please print out and complete and bring completed form to your consultation appointment.

Name: _____ D.O.B. _____ Ethnicity _____
 Address: _____ Ph.# (H) _____ (W/cell) _____
 City _____ State _____ Zip _____ Occupation _____
 May we call to confirm appointments # _____ How did you hear about us?
 and leave voice message? _____ Are you pregnant/nursing?
 What is your main concern? _____ EMAIL ADDRESS: _____
 _____ (for special internet promotions)
 Medications: _____

Clinical (check all that apply)

Skin

	Date of last exposure	Last exposure
Accutane		Moles
Herpes/Cold Sores		"Sensitive Skin"
Hypertrophic Scars		Skin Cancer
Metal Implants		Suntan
Pacemaker/Defibrillator		Self tan/booth
Polycystic Ovarian Synd		Botox
Allergies/Sensitivities		Collagen/Dermal Fillers
Vitiligo		Previous Laser
Sclerotherapy		Chemical Peels/Micro
Aspirin/St.Johns Wort/fish/Vit.E Oils/ginko		Waxing/Plucking
Clotting Disorders/coumadin		

Comments:

Skin Care Routine

Below for Clinician use

Plan

Benefits of procedure discussed
 Contraindications reviewed
 Risks reviewed (pigment changes, swelling, infection, scarring, reoccurrence, blistering)
 Probability of success reviewed
 Alternative procedures available
 Verbal/Written post-treatment instructions given
 Pre photos taken
 Next appointment scheduled: Date:

Comments:

Signature: Consultant

Clinician

Date: