SHAPE
Cosmetic Surgery & MedSpa

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SKIN CONSULT INTAKE FORM

Name______________________________________DOB____/___/____Today's date: ____________
Last First Mo Day Yr

Address:____

City:____________________________________ State:___________________ZIP:________________

Home Phone:( ) ___________Cell Phone:( ) ____________Work Phone:( ) _______________

E-mail____________________________________* **How did you hear about us?** _______________________

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
O	O	Are you using any prescribed medications? List: ________________________________
O	O	Are you using any herbal medications? List: ___________________________________
O	O	Do you take oral anti-coagulant (blood thinning) medication?
O	O	Are you allergic to any cosmetic ingredients, medications or foods? List:_____________
O	O	Are you pregnant or trying to become pregnant?
O	O	Do you use oral contraceptives?
O	O	Do you use hormone replacement therapy?
O	O	Do you smoke? How much? _______How long?_____When did you quit?___________
O	O	Do you spend a lot of time outdoors or use a tanning bed often?
O	O	Do you have any tattoos or permanent makeup?
O	O	Do you have any allergies to eggs, egg proteins, or human albumin?
O	O	Do you have any neuromuscular or autoimmune diseases?
O	O	Do you have any allergies to latex?
O	O	Do you have a fear of needles?

Please answer the following questions:

Which concerns apply to you? (Check all that apply):

O Uneven Skin Tone O Brown spots (Hyperpigmentation) O White spots (Hypopigmentation)
O Uneven skin tone O Visible exposed blood vessels O Hard bumps under skin
O Enlarged pores O Clogged pores O Blackheads /Whiteheads
O Acne O Excessive oiliness O Skin Laxity
O Upper lip lines O Wrinkles O Scarring
O Dry patches O Unwanted Hair O Varicose Veins
O Spider Veins O Stretch Marks O Cellulite
O Unwanted Body Fat O Other: ____

What is your skin type: O Dry O Combination O Oily O Normal

How much water do you consume per day?______________________

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

O Cleanser ______________ O Soap ________________O Toner ______________
O Moisturizer __________ O Night Cream _________ O Mask ______________
O Eye cream ___________ O Astringent ____________ O Glycolic Wash/Cleanser
O Scrub _______________ O Sunscreen____________ O Salicylic Wash/Cleanser
O Vitamin A Cream O Vitamin C Creams O Alpha or Beta Hydroxy
Cream

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list: ____
____

Have you ever had any of the following injectables or implants:

O Botox O Juvederm O Radiesse O Restylane O Perlane O Silicone O Hylaform O Collagen

O Lipo Dissolve O Other:____

* If so, then when was it done? ______________What area? ___________________________

Have you had any other cosmetic surgeries/procedures? __________________________________

When? ________________________________Were you pleased with the results? _______________
____

Please check any health problems, past or present:

O Seizures O Liver disease O Skin cancer O Hepatitis O Asthma
O Hormonal Problems O Diabetes O Cystic Acne O Thyroid O Cancer
O High Blood Pressure O Heart problems O Collagen (Lupus, Sarcoid, Scleroderma) O Vasovagal Syncope/Fainting

OOther:______________________________________

Do you have any of the following chronic skin disorders?

O Psoriasis O Dermatitis O Eczema O Keloid Scarring
O Fever Blisters O Cold Sores O Sun Blisters O Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

O Microdermabrasion O Acid Peel O Cosmetic Surgery O Accutane

Please Explain____

Are you currently removing hair by any of the following methods?

O Waxing O Tweezing O "Nair" type products
O Electrolysis O Laser Hair Removal

- If so, when was it done? ____________What area?___________________________________
- What type of laser/equipment?____

Notes:

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_________________________________ ___________________
Provider Name Date