WESTCOUNTY

PLASTIC SURGEONS
of Washington University

Skin Care Evaluation and Consent Form

Patient Name: _____

Age: _____ D.O.B:_____

E-mail address: _____

How did you hear about us:_____

Have you seen a Dermatologist in the past year? Yes No If yes, reason for visit_____

Are you currently under a Physician's care? Yes No If yes, reason for visit_____

Are you currently taking any medications ? Yes No If yes, please list_____

Are you currently taking any nutritional supplements? Yes No If yes, please list_____

Do you have a history of cold sores? Yes No Do you smoke? Yes No Do you exercise regularly? Yes No

Do you follow a restricted diet? Yes No Do you have regular menses? Yes No Are you pregnant? Yes No

Do you wear contact lenses? Yes No Do you have tendency to scar? Yes No

What do you like about your skin?_____

What would you like to improve? *Fine Lines* *Texture* *Tone* *Oiliness* *Pigmentation*

Dehydration *Acne* *Enlarged Pores* *Congestion* *Scarring* *Rosacea*

Allergies

Have you ever had an allergic reaction to any of the following: Asprin/Salicylates Milk Apples, Citrus, Grapes

Ingredients in skincare products? Yes No Fish, marine or iodine allergies? Yes No

If yes to any of the above, please explain_____

Exfoliation History

Have you ever had a chemical peel? Yes No

If yes, where/date_____Do you use Accutane, Retin A, Renova, or any other prescription skin products? Yes No

Are you currently using any products that contain the following ingredients? (Circle Areas)

Glycolic, Salicylic, or Lactic acids *OTC Retinols* *Exfoliating Scrubs* *Lighting Agents*

Sun Exposure

Minimal *Moderate* *Heavy* *Lifestyle* Do you wear sunscreen daily? Yes No Spf_____

Do you burn easily in moderate sunlight? Yes No Do you sunbathe or use tanning beds? Yes No How Often _____

Oil Secretion

Do you ever experience oily shine during the day? Yes No Occasionally Do you ever experience skin breakouts? Yes No Hormonal

Hydration

How much plain water do you consume daily? _____glasses

Do you ever experience these conditions on your skin? *Flakiness* *Tightness* *Obvious Dryness*

Vascular Activity

Telangiectasia or broken capillaries? Yes No (Circle Areas) Do you blush easily when nervous? Yes No

Nose *Cheek* *Chin* *Forehead* *Entire Face*

Do you have a tendency to redness when you exercise, drink alcohol, eat spicy foods? Yes No

Describe your skin care daily skin care routine/products?_____

_____

Occupation/Hobbies_____

Is there any other necessary information your skincare specialist should know before beginning your treatment?_____

Consent: I hereby attest that the above information is correct to the best of my knowledge. I agree to follow the recommendations and precautions informed to me by my skincare provider concerning the skin care treatment.

Patient Signature: _____ Today's Date: _____

Provider Signature: _____ Kristin Green / Kristi Reasons Look