Associated Skin Care Specialists

BOARD CERTIFIED DERMATOLOGISTS

Aesthetic Consultation Intake Form

Name_____ D.O.B._____ /_____ /_____

Address_____ State_____ Zip_____

Email_____

Approval to send you information regarding aesthetic promotions, products, and services? ☐ Yes ☐ No

Primary Number_____ Home / Cell Secondary Number_____ Home / Cell

Preferred method of contact ☐ Home ☐ Cell ☐ Work Approval to leave messages? ☐ Yes ☐ No

Are you currently a patient of Associated Skin Care Specialists P.A.? ☐ Yes ☐ No

Primary Dermatologist of Associated Skin Care Specialists P.A.:_____

Referred by:_____

Bart Endrizzi, M.D.
Frederick S. Fish, M.D.
Jeffrey M. Freed, M.D.
Susan M. Humphreys, M.D.
Steven E. Kempers, M.D.
Bailey Lee, M.D.
Jane S. Lindholm, M.D.
Jane H. Lisko, M.D.
Ann F. McGinn, M.D.
J. Daniel Mischke, M.D.
Ann M. Norland, M.D.
Soheil Y. Pakzad, M.D.
Scott P. Prawer, M.D., MS
Steven E. Prawer, M.D.
Erika J. Rabeni, M.D.
Jeffrey A. Squires, M.D.
Helen F. Tergin, M.D.
Roger H. Weenig, M.D.

■ **Primary concerns for today's consult/treatment:** _____

_____

■ **Secondary concern for today's consult/treatment:** _____

_____

■ **Have you addressed your concerns with a physician or aesthetician prior to today's treatment?** ☐ Yes ☐ No

■ **Indicate the following skin concerns:** (please check all that apply)

☐ Acne
☐ Broken Blood Vessels
☐ Brown Spots
☐ Crows Feet
☐ Facial Dryness
☐ Facial Oiliness
☐ Facial Volume Loss
☐ Forehead Lines/Frown Lines
☐ Lip Lines
☐ Lip Volume Loss
☐ Neck and Chest Discoloration
☐ Nose-to-Mouth Lines
☐ Red Spots/Flushing
☐ Scarring
☐ Skin Texture
☐ Thin, Short or Lightened Lashes
☐ Under Eye Circles/Crepiness or creping
☐ Uneven Skin Texture
☐ Unwanted Hair

■ **Please indicate the following services of interest to you:** (please check all that apply)

☐ BOTOX Cosmetics
☐ Chemical Peels
☐ Cosmetic Facial Treatments
☐ Cosmetic Laser Treatments
☐ Facial Injectables/Dermal Fillers
☐ General Skin Health/Product Advice
☐ Makeup
☐ Microdermabrasion
☐ SPF Advice
☐ Other_____

■ **When was the last time you received cosmetic consult or facial service:**_____
Type of service received:

__Botox __Chemical Peel __Cosmetic Consult __Dermal Filler __Facial __Laser treatment __Waxing

■ **Please describe any adverse reactions to previous cosmetic treatments:** _____

_____

■ **Please list all allergies:** _____

■ **Are you currently using any form of:** ☐ Retin-A ☐ Differin ☐ Tazorac ☐ Renova ☐ Glycolic Acid ☐ Salicylic Acid ☐ Hydroquinone ☐ Other _____

- Have you ever been on Accutane? ☐ Yes ☐ No Date of last treatment: ___ / ___ / ___
- Are you pregnant or lactating (breastfeeding)? ☐ Yes ☐ No
- Do you have a history of herpes simplex (cold sores)? ☐ Yes ☐ No
- Do you currently take an anti-viral medication for the prevention or treatment of cold sores? ☐ Yes ☐ No
- Do you have a history of lupus or any other auto-immune disease? ☐ Yes ☐ No
- Have you ever developed keloids (raised scars)? ☐ Yes ☐ No
- Do you tan on a regular basis? ☐ Yes ☐ No
- Do you have a history of atypical moles, Melanoma or skin cancer in your family? ☐ Yes ☐ No

■ **Please describe your current skin care regiment:**

Cleanse AM: _____ Cleanse PM: _____

Toner/Astringent AM: _____ Toner/Astringent PM: _____

Prescriptions/Treatment Products AM: _____ Prescriptions/ Treatment Products PM: _____

Prevention/Serum Products AM: _____ Prevention/Serum Products PM: _____

Moisturizer/Creams AM: _____ Moisturizer/Creams PM: _____

SPF: _____

Weekly At-home facial treatments:

Masks/ Scrubs/Other list: _____

■ **Please describe any adverse reactions to topical skin care products, makeup, and medications:** _____

_____

■ **Does your skin ever flake or feel tight and dry?** __Frequently __Occasionally __Very Rarely

■ **Do you feel oily a few hours after cleansing?** ☐ Yes ☐ No

■ **Do you feel your current skin care regiment is addressing your primary and secondary concerns listed today?** ☐ Yes ☐ No If no please specify: _____

_____

_____

_____

Patient Name (Please Print) Date

_____

Patient Signature Date

_____

Parent/Guardian Signature (If client under 18 years of age) Date

Relationship to Patient_____