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Date: ___________ **Name:** ______________________ **Email:** ______________________

In order for you to get the most out of your cosmetic consultation, please answer all of the following completely and bring it with you to the consultation.

What made you decide to schedule a cosmetic consultation?

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When you look in the mirror, what bothers you? (Check all that apply).

- ☐ Fine lines
- ☐ Deep lines
- ☐ Uneven color
- ☐ Brown spots
- ☐ Decreased skin tone
- ☐ Rough skin texture
- ☐ Sagging skin
- ☐ Acne scarring
- ☐ Other: ____

Past Medical History: (Circle Yes or No to answer each question)

- Do you have sensitive skin? Yes / No
- Do you have dry skin? Yes / No
- Do you have oily skin? Yes / No
- Is your skin sensitive to the sun? Yes / No
- Do you have rashes on your face? Yes / No
- Do you have lupus or other connective tissue diseases? Yes / No
- Do you have a tendency to scar? Yes / No
- Do you have a tendency to form dark marks on the skin after rashes, procedures, or minor skin irritation? Yes / No
- Are you pregnant or planning to become pregnant? Yes / No
- Are you breast-feeding or planning to breast-feed in the next 6 months? Yes / No
- Are you able to avoid tanning or excessive sun exposure? Yes / No
- Are you willing to avoid tanning or excessive sun exposure? Yes / No
- Have you had a sunburn recently? Yes / No
- Have you had or do you plan to have spa facial treatments, hair removal, or electrolysis? Yes / No If yes, what treatment and when? _________________________

- Are you using facial skin care regimens not prescribed or recommended by this office?
  Yes / No If yes, what are you using? ___________________________
- Have you had or are you planning to have cryosurgery (“freezing” of the skin) or other procedures on your face or cosmetically concerning areas? Yes / No
- Have you had or do you plan to have laser therapy? Yes / No
  If yes, what treatment and when? ____________________________
- Have you ever had “fever sores” or “cold sores” or herpes on the face? Yes / No
- Have you ever had warts on your face? Yes / No
- Are you using or have you ever used Retin A, Renova, Differin, Tazorac, and/or fading creams? Yes / No
  If yes, which ones and when did you last use them? ______________________
- Do you have a tendency to make large or thick scars? Yes / No
- Are you using or have you ever used isotretinoin (Accutane) or a related product?
  Yes / No If yes, when was the last time you used it? ___________________
- Are you receiving or have you ever received radiation to your skin? Yes / No
  If yes, where on your body and when was the last time you received it?
- Do you have a history of delayed wound healing? Yes / No
- Do you wear contact lenses? Yes / No
- Have you ever used Botox? Yes / No
- Do you have a known allergy to Botox or chemical peeling agents? Yes / No
- Do you have a known allergy to fragrances, preservatives, or anything else that comes in contact with your skin? Yes / No If yes, please list: _________________________
- Do you have neurological disease (disease that affects your nerves or nervous system) such as multiple sclerosis? Yes / No If yes, please list _______________________________
- Do you have a history of easy bruising and bleeding? Yes / No
- Do you have a previous history of ANY HEAD AND NECK SURGERY, including cosmetic and eye related surgery? Yes / No THIS IS VERY IMPORTANT. If yes, when and where? _____________________________
- Do you have any infections on or inside your body?
- Do you have any infections in your mouth or around your teeth? You should not have fillers if you have an infection.
- Do you have any dental procedures, colonoscopy, or other surgical procedures scheduled? You should not have any of these procedures done within 2 weeks before or 2 weeks after the injection of fillers.
- Are you able to avoid pressure to your face (i.e., goggles, scuba masks, CPAP masks) for at least 2 weeks after receiving fillers?
- Have you had or are you considering any other cosmetic procedures? Yes / No
  If yes, then please list them ____
- Have you had bad outcomes with previous cosmetic procedures? Yes / No
- Do you have a history of any psychiatric conditions such as depression, anxiety, or obsessive compulsive disorder? Yes / No

- Are you involved in any occupation were facial expressions are extremely important, such as acting, public speaking, or politics? Yes / No

Are you allergic to any medications (prescription or non prescription): Yes / No
If yes, please list: ____

Are you taking any prescription or non prescription medications, herbs, or other remedies: Yes / No If yes, please list: ________________________________

Do you smoke? Yes / No

Do you drink alcohol? Yes / No If yes, how much per day?________ per week? _____