

CONSULTATION & MEDICAL HISTORY FOR COSMETIC TREATMENTS

Dr. Monica Scheel

Last Name: _____ First Name: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

Best number to confirm an appointment? (circle one) H C W May we leave a message? Y / N

Date of Birth: _____ Age: _____ Email: _____

Referred by: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Reason(s) for consultation...circle what bothers you the most: lines/wrinkles, texture, dryness, dull appearance, blotchiness/uneven skin tones, freckles/brown (sun) spots, hair, acne, blackheads, scars, precancers, redness/blood vessels, frown lines, folds around nose/mouth, neck, chest, hands, other _____

Previous Cosmetic Treatments...circle: facials, microdermabrasion, chemical peels, laser, Botox, Juvederm – Restylane or other fillers, intense pulsed light, fractional light, photodynamic therapy, hair removal, CO₂ resurfacing, facelift, blepharoplasty, brow lift, other _____

Satisfaction, side effects and other results from previous treatments:

Current Skin Care Regimen/Products used:

Sunscreen Brand _____ SPF _____ Daily use? Y / N Sunscreen only when outside? Y / N

Cleanser, moisturizer, anti-aging creams, Retin-A, Vitamin C, Glycolic Acid, firming creams, lighteners, fade creams, other _____

AM Regimen _____

PM Regimen _____

Do you have ANY current or chronic medical illnesses that we should know about? Y / N

Please List _____

Do you have ANY allergies to medications, foods, latex or other substances? Y / N

Please List _____

Do you take/use ANY medications, both prescription and non-prescription, herbal or natural supplements, or topicals on a regular or daily basis? Y / N

Please list: _____

MEDICAL HISTORY QUESTIONNAIRE

Y / N Do you have a history of 'cold sores', herpes I or II, or hepatitis? Type? _____

Y / N Do you have a history of diabetes, hypertension, cholesterol, or problems with wound healing?

Y / N Do you have any sensitivity to heat, i.e. heat rash or hives?

Y / N Do you have any history of seizures?

Y / N Do you have a history of migraine headaches?

Y / N Do you have a history of keloid or hypertrophic scarring or abnormal scarring?

Y / N Do you have any active infections or compromised ability to healing?

Y / N Do you take St. John's Wort or any anticoagulants? _____

Y / N Do you have any permanent make-up, implants or tattoos? _____

Y / N Do you have any open lesions in the area to be treated?

Y / N Have you taken Accutane in the last 6 months?

Y / N Have you had or are you undergoing any treatments for cancer? Type _____

Y / N Have you used any exfoliating creams or products (*Retin A, Differin, Glycolic acid, Alpha-Hydroxy acid products*) in the past 2 weeks?

Y / N Have you had mechanical epilation (*plucking, tweezing, electrolysis, or sugaring*) less than 4 weeks ago?

Y / N Have you had any unprotected sun exposure, used self-tanning creams or tanning beds in the last 4-6 weeks to the area to be treated?

Y / N Are you sensitive to sunscreens or anti-aging creams?

For Women:

Y / N Are you or could you be pregnant?

Y / N / NA Are your periods regular?

To avoid misunderstandings please carefully read our Financial Policy listed here. Cosmetic appointments require a 25% deposit on your procedure to schedule. The balance is due after your first treatment. If you miss or cancel your appointment with less than 24 hours notice, you will be billed a \$50 cancellation fee and be required to leave a credit card number to rebook. There is a \$25 check return fee. Your signature below indicates that you understand and accept our policy, and the information contained in this document is correct.

Signature: _____

Date: _____