SOUTHSIDE DERMATOLOGY & LASER COSMETIC CENTER

COSMETIC CONSULTATION & MEDICAL HISTORY

NAME: _____ **DOB/AGE:** _____ **DATE:** _____

ADDRESS: _____

_____

EMAIL: _____ **PHONE:** _____

Please present ID (Driver's License) to receptionist.

How did you hear about us? _____

☐ Google ☐ Real Self ☐ Yelp ☐ Magazine Ad ☐ Radio ☐ TV ☐ Southside Dermatology

☐ Physician/Provider (Name)_____ ☐ Patient (Name)_____

Is there a special event that you would like to look your best for? When is your event? (i.e weddings, birthdays, reunions, graduations, etc.) _____

Do you have a budget? ☐ No ☐ $0-$1,000 ☐ $1,000-$2,500 ☐ $2,500-$5,000 ☐ $5,000-$10,000

Are you interested in a financial payment plan? (ie Care Credit, Alphaeon Credit): ☐ No ☐ Yes

Please list in order of priority (1 most important to 5 least important) your concerns:

__ Botox/Dysport/Xeomin/Jeuveau
__ Laser Hair Removal
__ Rosacea/Vessels/Red spots
__ Laser Tattoo Removal (PicoWay, Enlighten)
__ Eye Wrinkles/Under Eyes Darkness
__ Lip Wrinkles
__ Neck Wrinkles
__ Aging Hands
__ Chest Wrinkles
__ Acne/Acne Scarring
__ Stretch Marks
__ Scars (Keloids/Traumatic/Burns)
__ Microdermabrasion
__ NovaLash Eyelash Extensions
__ Lipotransfer (BeautiFILL)
__ Fillers (Restylane, Juvederm, Radiesse, Sculptra, Bellafill)
__ Laser Resurfacing (CO2, Erbium, Halo, Fraxel)
__ Brown Spots/Age Spots/Melasma
__ Laser Leg Veins
__ Microneedling RF (Secret RF, Profound)
__ Thread Lifts/Instalift
__ Ultherapy
__ Hair Loss/PRP
__ Excessive Sweating/miraDry
__ Photofacial/BBL
__ Photodynamic Therapy (PDT)
__ Cellulite Removal
__ Chemical Peels/Dermaplaning
__ Microblading/Permanent Make-Up
__ Skin Care Advice/Products
__ Non-invasive Fat Reduction & Body Contouring (Coolsculpting, TruSculpt ID, Emsculpt, Velasahape)
__ Other concerns: _____

Please tell us about your skin (check all that apply):

☐ Sensitive
☐ Dry
☐ Oily
☐ Normal
☐ Combination
☐ Blackheads
☐ Clogged pores
☐ Large pores
☐ Acne Scarred
☐ Mature/Resilient
☐ Uneven/Blotchy
☐ Sun Damaged/Freckled
☐ Dehydrated
☐ Acne on body
☐ Menses related breakouts
☐ Other:_____
☐ Reactions to skin care products:_____

Please indicate method of payment today (if applicable): VISA/MC/AMEX/CARE CREDIT/CHECK/CASH

COSMETIC CONSULTATION & MEDICAL HISTORY (Part 2)

Your Ethnicity (check all that applies):

☐ Caucasian ☐ Asian/Island Pacific ☐ African American
☐ Native American ☐ Hispanic/Latino ☐ Other:_____

Your Response to Sun Exposure: (Skin Type: 1 2 3 4 5 6)

☐ Always burns, never tans ☐ Usually burns, tans with difficulty ☐ Sometimes mild burn, tans average
☐ Rarely burns, tans with ease ☐ Very rarely burns, tans very easily ☐ No burns, tans very easily

Current Skin Care Regimen (list products):

_____

Medications: _____

Allergies: _____

Reactions to anesthesia (including lidocaine, epinephrine, twilight, gas). Please describe:

_____

Medical History:

☐ Smoking ☐ HIV/Hepatitis ☐ Fibromyalgia
☐ Cold Sores/Fever Blisters ☐ Hernias ☐ Connective Tissue Disorder
☐ Abnormal Healing/Raised Scars ☐ Waxing/Electrolysis ☐ Melasma
☐ Cold Sores/Fever Blister ☐ Hernias ☐ Connective Tissue Disorder
☐ Diabetes ☐ Thyroid Disorder ☐ Bleeding disorder
☐ Photosensitivity Disorder ☐ Neurological Disorder ☐ Heart/Cardiac Disorder
☐ Pulmonary Disorder ☐ Endocrine/Hormonal Disorder ☐ Cancer: _____
☐ Anxiety ☐ Depression ☐ Other Mental Health
☐ Accutane (last date used: _____
☐ Other _____

Ob/Gyn History:

☐ Currently pregnant (if not, date of last menses: _____) ☐ Birth Control Pill
☐ Abnormal PAP Smear ☐ Last Normal PAP Smear:_____ ☐ IUD
☐ Sling/MESH ☐ Abnormal vaginal discharge ☐ Pain with intercourse
☐ Vaginal Dryness ☐ Stress Urinary Incontinence ☐ _____

☐ **Cosmetic Procedures (list)**:_____

☐ **Plastic Surgery (list)**:_____

I verify that the above information is correct and I have disclosed all relevant history to the staff and providers at Southside Dermatology & Laser Cosmetic Center.

Signature: _____ **Date: _____**

Signature of Guardian: _____ **Date: _____**