PATIENT INFORMATION

Skin Care Services

DATE____________________**NAME**____

ADDRESS____

CITY__________________________________ **STATE**____________ **ZIP CODE**_______________

HOME PHONE____________________________ **CELL PHONE**___________________________

OFFICE PHONE______________________ **E-MAIL**______________________________________

WOULD YOU LIKE TO RECEIVE E-MAILS REGARDING SPECIALS AND EVENTS? **YES**_____ **NO**_____

DATE OF BIRTH_________________ **REFERRED BY**______________________________________

PHOTOGRAPHS:
Photos will be used as documentation only and will not be used for marketing/education unless otherwise agreed to in writing.

HOME CARE COMPLIANCE:
In an effort to achieve the best clinical results possible, it is highly recommended that professional treatments be followed up with specific home care products according to skin type and condition. I understand that if I choose not to purchase specific treatment products, I may not achieve the results for which I am looking. I also agree to inform the aesthetician immediately of any concerns, questions or reactions I may have pertaining to the treatments or home care products.

PRIVACY:
I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. By signing below, I acknowledge being notified of the privacy practices of the Plastic Surgery Institute of Washington. Please ask the front desk if you would like a copy of said privacy practices.

____ ___________________________
SIGNATURE DATE

____
PRINTED NAME

SKIN AND HEALTH HISTORY

Are you currently under the care of a physician for your skin? If yes, why? ___________________________
____

Have you recently had a Chemical Peel, Microdermabrasion, Laser Resurfacing or Facial Surgery? If yes, please elaborate:
____
____

Have you ever or are you currently taking Accutane? If yes, please elaborate: _______________________
____

Please list any oral medications or supplements you are taking: _____________________________________

Have you ever experienced hypersensitivity (rash, irritation, peeling, swelling, hives, etc) to the following:

___Aspirin	___Iodine	___Sulfa Drugs
___Latex	___Jewelry	___Fabrics
___Cosmetics	___Penicillin	___Other___________________________

Complete most recent product regime:
AM:____
____
PM:____
____

Do you have a healthy diet?	Y	N	
Do you work in a stressful job?	Y	N	
Do you smoke?	Y	N	If yes, how often?___________________________
Do you consume alcohol?	Y	N	If yes, how often?___________________________
Do you exercise?	Y	N	If yes, how often?___________________________
Do you drink water?	Y	N	If yes, how much?___________________________

Do you take birth control pills?	Y	N	If yes, which type?___________________________
Are you going through menopause?	Y	N	
Are you on hormone replacement?	Y	N	If yes, what type?___________________________

During pregnancy, did you ever experience hyperpigmentation or "pregnancy mask"? Y N

Do you “flush” or appear reddened easily when you eat spicy food, drink alcohol, get angry or embarrassed or when you go in the sun, etc.? Y N

Have you EVER had a “cold score”? Y N

Do you have any history of acne or periodic breakout? Y N

___Pimples ___Whiteheads
___Acne Scars ___Blackheads
___Cysts ___Flakiness

How do you tan?

__I Burn __II Usually Burn __III Sometimes Burn
__IV Rarely Burn __V Never Burn/Brown __VI Never Burn/Black

Are you interested in learning more about the following?

Botox/Fillers
Having longer, thicker lashes
Laser hair removal
Laser skin resurfacing and other laser treatments

Other, please specify____