SHAPE
Cosmetic Surgery & MedSpa

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SKIN CONSULT INTAKE FORM

Name_____DOB____/___/____Today's date: _____
Last First Mo Day Yr

Address:_____

City:_____ State:_____ZIP:_____

Home Phone:( ) _____Cell Phone:( ) _____Work Phone:( ) _____

E-mail_____* **How did you hear about us?** _____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES	NO	
O	O	Are you using any prescribed medications? List: _____
O	O	Are you using any herbal medications? List: _____
O	O	Do you take oral anti-coagulant (blood thinning) medication?
O	O	Are you allergic to any cosmetic ingredients, medications or foods? List:_____
O	O	Are you pregnant or trying to become pregnant?
O	O	Do you use oral contraceptives?
O	O	Do you use hormone replacement therapy?
O	O	Do you smoke? How much? _____How long?_____When did you quit?_____
O	O	Do you spend a lot of time outdoors or use a tanning bed often?
O	O	Do you have any tattoos or permanent makeup?
O	O	Do you have any allergies to eggs, egg proteins, or human albumin?
O	O	Do you have any neuromuscular or autoimmune diseases?
O	O	Do you have any allergies to latex?
O	O	Do you have a fear of needles?

Please answer the following questions:

Which concerns apply to you? (Check all that apply):

O Uneven Skin Tone	O Brown spots (Hyperpigmentation)	O White spots (Hypopigmentation)
O Uneven skin tone	O Visible exposed blood vessels	O Hard bumps under skin
O Enlarged pores	O Clogged pores	O Blackheads /Whiteheads
O Acne	O Excessive oiliness	O Skin Laxity
O Upper lip lines	O Wrinkles	O Scarring
O Dry patches	O Unwanted Hair	O Varicose Veins
O Spider Veins	O Stretch Marks	O Cellulite
O Unwanted Body Fat	O Other: _____	

What is your skin type: O Dry O Combination O Oily O Normal

How much water do you consume per day?_____

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

O Cleanser _____	O Soap _____	O Toner _____
O Moisturizer _____	O Night Cream _____	O Mask _____
O Eye cream _____	O Astringent _____	O Glycolic Wash/Cleanser
O Scrub _____	O Sunscreen_____	O Salicylic Wash/Cleanser
O Vitamin A Cream	O Vitamin C Creams	O Alpha or Beta Hydroxy Cream

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Please list: _____

_____

Have you ever had any of the following injectables or implants:

O Botox O Juvederm O Radiesse O Restylane O Perlane O Silicone O Hylaform O Collagen

O Lipo Dissolve O Other:_____

* If so, then when was it done? _____What area? _____

Have you had any other cosmetic surgeries/procedures? _____

When? _____Were you pleased with the results? _____

_____

Please check any health problems, past or present:

O Seizures O Liver disease O Skin cancer O Hepatitis O Asthma
O Hormonal Problems O Diabetes O Cystic Acne O Thyroid O Cancer
O High Blood Pressure O Heart problems O Collagen (Lupus, Sarcoid, Scleroderma) O Vasovagal Syncope/Fainting

O Other:_____

Do you have any of the following chronic skin disorders?

O Psoriasis O Dermatitis O Eczema O Keloid Scarring
O Fever Blisters O Cold Sores O Sun Blisters O Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

O Microdermabrasion O Acid Peel O Cosmetic Surgery O Accutane

Please Explain_____

Are you currently removing hair by any of the following methods?

O Waxing O Tweezing O "Nair" type products
O Electrolysis O Laser Hair Removal

- If so, when was it done? _____What area?_____
- What type of laser/equipment?_____

Notes:

_____

_____

_____

_____

_____

_____ _____
Provider Name Date