Dermatology Center of Williamsburg
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Williamsburg, VA 23188

Print Form to Sign & Submit

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Cosmetic Procedures
Patient Consultation and History

Today's Date _____

Patient Name _____ Birth Date _____

Address _____ City _____ State Virginia _____ Zip _____

Phone _____ Email _____

Have you ever seen a dermatologist for your skin? ◯ Yes ◯ No

Are you pregnant or lactating? ◯ Yes ◯ No

Have you ever used Accutane? ◯ Yes ◯ No If yes, when? _____

What topical medications have you used or do you currently use? (Please check all that apply.)

☐ Retin A ☐ Glycolic ☐ Lactic Acid ☐ None

What oral medications have you used or do you currently use? (Please check all that apply.)

☐ Antibiotics ☐ Hormones or Birth Control ☐ Diuretics ☐ Other, please describe _____

Have you had any skin acid peels? ◯ Yes ◯ No Have you ever had laser surgery or dermabrasion? ◯ Yes ◯ No

Have you ever had a microdermabrasion treament? ◯ Yes ◯ No Have you ever had Botox/Collagen fillers? ◯ Yes ◯ No

What type of skin care products are you using now? _____

If you have had Botox or Collagen Fillers when did you have them? _____

HYPERSENSITIVITY & FRAGILITY

Have you ever had a skin allergy? ◯ Yes ◯ No Do you have any known drug allergies? ◯ Yes ◯ No

What are you allergic to? _____

FREE RADICAL EXPOSURE

Do you smoke? ◯ Yes ◯ No Do you consume alcohol? ◯ Yes ◯ No Do you exercise? ◯ Yes ◯ No

Do you take blood thinners? ◯ Yes ◯ No Do you take vitamins? ◯ Yes ◯ No Do you take laxatives or diuretics? ◯ Yes ◯ No

How much water do you consume daily? _____

HORMONES

Are you going through menopause? ◯ Yes ◯ No During pregnancy, did you get hyperpigmentation/masking? ◯ Yes ◯ No

SUN HISTORY & LIFESTYLE

What percentage of time do you spend in the sun? Summer (%) _____ Winter (%) _____

Do you use sunblock? ◯ Yes ◯ No Do you go to a tanning salon? ◯ Yes ◯ No

Do you have, or have you ever had, cold sores or herpes? ◯ Yes ◯ No

Have you or any member of your family had skin cancer? ◯ Yes ◯ No

SKIN TYPE (Please choose **one** per question.)

Does your skin ever flake or feel tight and dry? ☐ Frequently ☐ Occasionally ☐ Rarely

Is your skin ever shiny a few hours after cleansing? ☐ Frequently ☐ Occasionally ☐ Rarely

How often do you experience blackheads or blemishes? ☐ Frequently ☐ Occasionally ☐ Rarely

How noticeable are your pores? ◯ Very ◯ Not Very

FITZPATRICK CLASSIFICATION SYSTEM (Choose one skin type from the below drop-down which best suits.)

Please select from the below options. _____

PIGMENTATION

Is your pigmentation (Please choose **one**.) ☐ Even ☐ Uneven ☐ Birthmark ☐ Pregnancy Mask

VASCULARITY

Broken Capillaries (Please choose **all** that apply.) ☐ None ☐ Cheeks ☐ Chin ☐ Forehead ☐ Entire Face

Do you blush easily? ◯ Yes ◯ No

ACNE

Do you have any history of some or periodic breakouts? ◯ Yes ◯ No

Rosacea? ◯ Yes ◯ No

ABILITY TO HEAL

Does your skin appear fragile? ◯ Yes ◯ No

Do you form thick or raised scars? ◯ Yes ◯ No

Are you a diabetic? ◯ Yes ◯ No

Do you wax or use depiliatories? ◯ Yes ◯ No

Do you have any health problems?

PATIENT OBJECTIVE

What specific areas do you want treated? (Please check all that apply.)

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Hands ☐ Forearms

☐ Other, please describe

PATIENT PRINTED NAME _____

RESPONSIBLE PARTY/PATIENT SIGNATURE _____ DATE_____

*****Please print to sign and date.*****