Stephanie Cogliano Laser and Electrology Associates

Andrea Purcell, Licensed Esthetician

PATIENT CONSULTATION AND HISTORY FORM

FOR SKIN CARE TREATMENTS

Patient Name: _____

Address: _____

Telephone: _____ Birth Date: _____

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

Are you pregnant or lactating? _____ Yes _____ No

Have you used Accutane? _____ Yes _____ No

What topical medications do you use or have you used?

___ Retin-A ____ Glycolic ____ Lactic Acid Other: _____

What oral medications have you used or do you currently use?

____ Antibiotics _____ Hormones or Birth Control ____ Diuretics Other: _____

Have you had any skin acid peels? _____ Yes _____ No

Have you ever had laser surgery or dermabrasion? _____ Yes _____ No

Have you ever had collagen injections? _____ Yes _____ No

How often? _____

Where? _____

Have you ever had a microdermabrasion treatment? _____ Yes _____ No

Do you get facials? _____ Yes _____ No

What type of skin care products do you currently use? _____

_____

HYPERSENSTIVITY & FRAGILITY

Have you ever had a skin allergy? _____ Yes _____ No

Do you have any know drug allergies? _____ Yes _____ No

Do you experience any claustrophobia? _____ Yes _____ No

What type of massage do you prefer? _____ Light _____ Firm

What level do you consider your pain threshold to be? _____ High _____ Low

What temperature of water do you use to cleanse? _____ Cool _____ Warm _____ Hot

FREE RADICAL EXPOSURE

Do you smoke? _____ Yes _____ No

Do you consume alcohol? _____ Yes _____ No

Do you have a regular diet? _____ Yes _____ No

Do you exercise? _____ Yes _____ No

Do you take vitamins? _____ Yes _____ No

How much water do you consume daily? _____

Do you take laxatives or diuretics? _____Yes _____ No

HORMONES

Do you have regular periods? _____Yes _____ No

Are you going through menopause? _____ Yes _____ No

During pregnancy, did you get hyperpigmentation or masking? _____ Yes _____ No

Are you taking oral contraceptions? _____ Yes _____ No

Are you trying to become pregnant? _____ Yes _____ No

Are you currently having or due for your menstrual period? _____ Yes _____ No

SUN HISTORY & LIFESTYLE

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

In the past have you lived in a sunbelt and sunbathed? _____ Yes _____ No

In the past have you neglected to use sunblock? _____ Yes _____ No

Do you go to a tanning salon? _____ Yes _____ No

Circle your level of stress (1 low, 10 high) 1 2 3 4 5 6 7 8 9 10

Do you now or at any time in the past, get cold sores or herpes? _____ Yes _____ No

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

SKIN TYPE

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

FITZPATRIC CLASSIFICATION SYSTEM (select one skin type below which best suits you)

Skin Type:	**Skin Color:**	**Characteritics:**
I	**White**	**Always burns, never tans**
II	**White**	**Usually burns, tans less than average**
III	**White**	**Sometimes mild burn, tans about average**
IV	**White**	**Rarely burns, tans more than average**
V	**Brown**	**Rarely burns, tans profusely**
VI	**Black**	**Never burns, deeply pigmented**

PIGMENTATION

Is your pigmentation: Even Uneven Birthmark Pregnancy Mask

VASCULARITY

Broken Capillaries: Nose Cheeks Chin Forehead Entire Face

Do you blush easily? _____ Yes _____ No

ACNE

Do you have any history of acne or periodic breakouts? _____
_____
_____
_____
Rosacea? _____

ABILITY TO HEAL

Does your skin appear fragile? _____ Yes _____ No

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

Do you have any health problems? _____

Are you a Diabetic? _____

Do you wax or use depilatories? _____ Yes _____ No

PATIENT OBJECTIVE:

What specific areas do you want treated? _____ Face _____ Neck _____ Chest____ Back ____ Hands_____ Forearms _____ Other: _____
_____

TREATMENT PLAN

_____
_____
_____
_____