SANTA FE PLASTIC SURGERY CENTER

MEDICAL SKINCARE ASSESSMENT

1631 Hospital Drive, Suite 150 | Santa Fe, NM 87505 | T 505 988 2215 | F 505 984 0373

Date _____

Name _____ DOB _____

PERSONAL HISTORY

Do you wear contact lenses? ☐ Yes ☐ No

Are you currently seeing a physician for any reason? ☐ Yes ☐ No

If yes, list reason: _____

Have you ever seen a physician or technician specifically for a skin problem or skincare? ☐ Yes ☐ No

If yes, when and for what reason? _____

Are you currently under any other physician's or technician's care for your skin? ☐ Yes ☐ No

If yes, detail reason(s): _____

Have you or any family member ever had a skin lesion removed by a physician? ☐ Yes ☐ No

If yes, who had lesion removed? _____ Anatomical location of lesion? _____

Do you have any health problems? ☐Yes ☐No

If yes, list: _____

Do you have any allergies or skin sensitivities? ☐ Yes ☐ No

If yes, list all: _____

Do you currently take any oral medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(Include oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc.)

If yes, list: _____

Do you use any topical medications (prescriptive pharmaceuticals)? ☐ Yes ☐ No
(Include Retin-A®, hydroquinone, Accutane®, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

If yes, list: _____

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Have you ever taken Accutane®?

☐ I currently take Accutane®. Dosage prescribed _____ Frequency taken _____

☐ I took Accutane® in the past. Date discontinued _____ Dosage/frequency _____

☐ I have never taken Accutane®

Have you ever had a cold sore? ☐ Yes ☐ No If yes, when was your last cold sore? _____

Do you ever use depilatories or waxes on your face? ☐ Yes ☐ No If yes, when last used? _____

Do you smoke? ☐ Yes ☐ No If yes, how much /often? _____

Do you consume alcohol? ☐ Yes ☐ No If yes, frequency/amount? _____

Do you have a healthy diet? ☐ Yes ☐ No

List any dietary concerns _____

Do you exercise? ☐ Yes ☐ No If yes, how often? Type(s)? _____

Do you take vitamins? ☐ Yes ☐ No If yes, what type(s)? _____

How many glasses of water do you drink per day? _____

FOR WOMAN ONLY:

Do you have regular periods? ☐ Yes ☐ No Are you going through menopause? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No Are you in fertility program? ☐ Yes ☐ No

Are you pregnant or lactating? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No

If yes, during pregnancy did you ever experience hyperpigmentation or a “pregnancy mask”? ☐ Yes ☐ No

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SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures or treatments? ☐ Yes ☐ No *(If no, skip this section.)*

Microdermabrasion ☐ Yes ☐ No Date of last procedure _____

Chemical Peel(s) ☐ Yes ☐ No Type/Date _____

Phototherapy ☐ Yes ☐ No Type/Date _____

Laser Resurfacing ☐ Yes ☐ No Type/Date _____

Radiofrequency ☐ Yes ☐ No Type/Date _____

Dermabrasion ☐ Yes ☐ No Type/Date _____

Facial Surgery ☐ Yes ☐ No Type/Date _____

Other procedures/dates? _____

Additional comments about above procedure(s): _____

_____

OILY SKIN OR ACNE

Any acne breakout? ☐ Yes ☐ No

If yes, select types: ☐ Blackheads ☐ Whiteheads ☐ Enlarged Pores ☐ Pustules ☐ Large pores ☐ Cysts

Do you have any history of acne or periodic breakout? ☐ Yes ☐ No If yes: ☐ Now? ☐ In the past?

Do you only experience breakout during or around your menstrual cycle? ☐ Yes ☐ No

Do you always have a pimple or some type of breakout? ☐ Yes ☐ No

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

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

How noticeable are your pores? ☐ Very ☐ T-zone only ☐ Not very noticeable

(The T-Zone is the part of your face that is made up of the forehead, nose, chin and area circling the mouth. This area is called the T-Zone because it shaped like the letter T.)

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SENSITIVE , INTOLERANT OR DRY SKIN

Allergic To: ☐ Lavender ☐ Rose Oil ☐ Ylang Ylang ☐ None Of These

Do you flush or redden when you eat spicy food, drink alcohol, get angry, go into the sun, etc.? ☐Yes ☐No

Does your skin ever get flaky or itch? ☐ Yes ☐ No If yes, is it: ☐ Seasonal ☐ All the time

Have you ever been diagnosed with Rosacea? ☐ Yes ☐ No If yes, when? _____

Do you have difficulty healing from a cut or burn? ☐ Yes ☐ No

If yes, explain: _____

Have you ever had keloid scarring? ☐ Yes ☐ No

If yes, explain: _____

PREMATURELY AGED AND /OR HYPERPIGMENTED SKIN

Do you have any of these types of facial wrinkles? ☐ Deep Wrinkles ☐ Crows Feet ☐ Fine Lines ☐ Skin Laxity

Have you been treated with: ☐ Botox ☐ Fillers If yes, date of last treatment: _____

Do you work inside? ☐ Yes ☐ No Occupation: _____

Are your hobbies done mostly outside? ☐ Yes ☐ No Hobbies: _____

In the past (including childhood), did you live in a sun belt? ☐ Yes ☐ No

If yes, where? _____

In the past have you neglected to use a sunscreen when outdoors? ☐Yes ☐ No

Do you ever use tanning beds? ☐ Yes ☐ No If yes, when? _____

Do you currently wear a sun protection product all day, every day? ☐ Yes ☐ No

Are you willing to wear a sun protection product all day, every day? ☐ Yes ☐ No

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Fitzpatrick Scale: How do you tan?

☐ Burn ☐ Usually Burn ☐ Sometimes Burn

☐ Rarely Burn ☐ Never Burn: "Brown" ☐ Never Burn: "Black"

Is your skin pigmentation (skin discoloration): ☐ Even ☐ Uneven ☐ Birthmark(s) ☐ Pregnancy Mask

What is your Ethnicity and Race (heritage)? _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN?

1. _____

2. _____

WHAT SPECIFIC SKIN AREAS DO YOU WANT TO TREAT?

☐ Face ☐ Neck ☐ Chest ☐ Back ☐ Other: _____

PATIENT SIGNATURE: _____

Date: _____

TECHNICIAN SIGNATURE: _____

Date: _____

M.D. SIGNATURE: _____

Date: _____

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CONSULTATION + RELEASE FORM

PLEASE READ CAREFULLY, COMPLETE, SIGN, AND DATE THIS FORM PRIOR TO TREATMENT

Name: _____ Phone: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ HYDRAFACIAL® ☐ LED LIGHT THERAPY ☐ LYMPHATIC/MASSAGE THERAPY ☐ MICRODERMABRASION

SECTION 1: MEDICAL INFORMATION

YES	NO	ABSOLUTE CONTRAINDICATIONS
☐	☐	Accutane or other similar medication (in the past year)
☐	☐	Autoimmune disease, HIV, lupus, hepatitis, scleroderma
☐	☐	Active Infection in the treatment area
☐	☐	Melanoma or lesions suspected of malignancy
☐	☐	Active Sunburn
☐	☐	Pregnancy (medical-legal)
☐	☐	Breast feeding (medical-legal, may increase skin sensitivity of likelihood oh PIH)
☐	☐	Epilepsy Contraindicated for LED light therapy
		RELATIVE CONTRAINDICATIONS
☐	☐	Anticoagulants therapy (use lower settings)
☐	☐	Very thin skin
☐	☐	Other Aesthetic Treatments: Botox: wait 5-7days; Fillers: wait 7-10 days: Peels: wait 30 days
☐	☐	Laser Treatments: wait until lesions heal & swelling & redness is resolved
		OTHER CONCERNS
☐	☐	Keloids: avoid direct contact
☐	☐	Rosacea, telangiectasia (use lower vacuum)
☐	☐	Unrealistic expectations

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If you answered YES to any of the above questions please explain: _____

_____

Please list any known allergies: _____

_____

SECTION 2: CLIENT CONSENT FORM *(Initial each acknowledgement line below)*

_____ 1. I acknowledge that my skin might experience temporary irritation, tightness, or redness, which usually dissipates within 72 hours depending on skin sensitivity.

_____ 2. I acknowledge that if I fail to use a minimal sunscreen (SPF30) and follow the direction for use, I am more susceptible to sunburn, sun damage and hyperpigmentation. I should avoid excessive sun exposure, especially between 10 am–2 pm.

_____ 3. I have disclosed my history of allergies above and I acknowledge that if I am allergic to one or more of the ingredients in the products used. I may experience an allergic reaction.

_____ 4. I hereby agree to have the treatment performed and agree to follow all pre- and post-treatment instructions.

_____ 5. I acknowledge that I have answered all questions truthfully and completely.

_____ 6. I release Edge Systems, and the management and staff of Santa Fe Plastic Surgery Center from any and all liability associated with any injuries and /or current or future conditions resulting from the skin care procedure or products.

_____ 7. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval.

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provide above are complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Operator Signature: _____ Date: _____