

Name :	Date:
Phone: _() E	-Mail:
What skin care products are you currently using	g?
Have you ever had a reaction or sensitivity to a skin product? If yes, please explain	
Do you use daily sunscreen? Br	and:
Have you ever had a cosmetic treatment? $\Box$	Botox □ Fraxel □ Facial □ Filler Microderm □ Chemical peel □ Other
Date of last treatment:	
Do you smoke? □ yes □ no	
What are your primary areas of concern?	
☐ Fine lines ☐ Pigmentation ☐ Une	ven texture □ Scarring □ Pore size □ Acne
☐ Sun Damage ☐ Broken Blood Vess	sels   □ Spider Veins   □ Laxity
Other:	
What type of skin do you believe you have?	
□ Dry □ Oily □ Combination □ S	ensitive   Acne Other:
What procedures are you interested in learning more about?  □ Microdermabrasion □ Hydrafacials □ Facials □ Chemical peels □ Coolsculpting □ Photodynamic therapy □ Botox □ Fillers □ Sculptra	
Other	
Do you have ? □ Difficulty healing □ Bruis	e easily   Bruise excessively   Thick Scars
□ Acne □ Rosacea □ Herpes (cold so	res)   Latex allergy   Hepatitis   HIV
	was your last sun exposure?

Date

Signature