New England Dermatology & Laser Center
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COSMETIC CONSULTATION QUESTIONNAIRE

Patient Name: _____ **Date: _____ Chart#: _____**

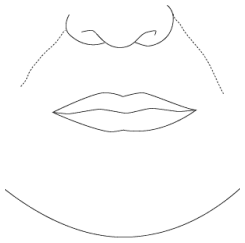
Gender: M F Age _____ Date of birth: _____

Primary cosmetic concern(s): _____

_____

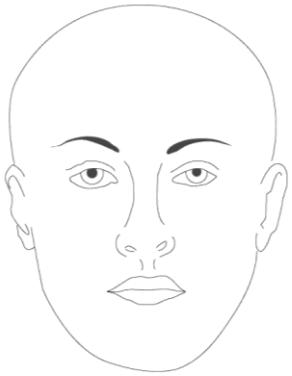
Please prioritize your cosmetic concerns by placing "1" next to the item which concerns you the most, "2" next to a second concern if there is one, etc.

_____ Red spots/blood vessels
_____ Brown spots
_____ Lines/wrinkles
_____ Scars
_____ Skin texture/tone/tightening
_____ Facial/body hair
_____ Moles/growths
_____ Other:_____



Please prioritize the areas of concern to you by placing "1" next to the area of most concern, "2" next to a second concern if there is one, etc.

_____ Face
_____ Forehead
_____ Around the eyes
_____ Cheeks
_____ Around the mouth
_____ Lips
_____ Neck
_____ Chest
_____ Arms and hands
_____ Legs and feet
_____ Other:_____



Do you consider your facial skin to be: Dry – Normal – Oily – Combination ?

Very sensitive – Somewhat sensitive – Not sensitive to facial products?

Please list the names of all the skin products you apply to your face on a daily basis in order of use. Include cleansers, toners, moisturizers, medications prescribed or otherwise, including specialty products such as masks, wrinkle creams, spot removers, vitamin C, skin lighteners, sunblocks, retinoids, glycolic acids, hydroquinones, etc.
Morning routine:

Evening routine:

Do you go to a spa, have facials, or see an aesthetician? □ No □ Yes
If yes, how frequently and what procedures are performed?_____
_____

Please circle any cosmetic treatments or procedures you have had performed in a physician's office?
Hair removal (waxing/electrolysis/laser) Microdermabrasion Chemical peels Botox Liposuction Sclerotherapy Fillers (collagen Restylane Perlane Juvederm Silicone Sculptra Radiesse fat injections) other_____
Laser treatments for (facial rejuvenation, facial resurfacing, brown spots, blood vessels, wrinkles, hair removal) other_____
Plastic surgery procedures:_____

Each of us has an idea of how we would like to approach and address concerns and new procedures. Please rate your approach on a scale of 1-5:

Very cautious → Moderately reserved → Aggressive

1 2 3 4 5

OVER→

Please circle the option that best describes you: When in the sun, I:
A. Always burn and never tan
B. Always burn but sometimes tan
C. Sometimes burn and sometimes tan
D. Never burn and always tan

What is your ethnicity? Caucasian -- Asian -- Hispanic -- African-American -- Other_____
What is your natural hair color? Blonde -- Red -- Brown -- Black
What is your natural eye color? Blue -- Hazel -- Green -- Brown
Regarding your sun exposure, do your feel that you have had: Less than average -- About average -- Too much

Have you or do you currently go indoor tanning?	□ No	□ Yes
Do you currently smoke?	□ No	□ Yes
Do you wear sunscreen/sunblock or a product which contains one every day all year round?	□ No	□ Yes

Past and Active Medical Problems:_____

_____

_____

_____

Previous major surgeries and dates:_____

_____

_____

Medications (Please list all prescription and over the counter medications including aspirin, over the counter pain relievers, vitamins and herbals.): _____

_____

_____

Please circle any of the following that you are currently taking or take on an "as needed" basis: aspirin vitamin E ibuprofen Aleve Motrin Midol naprosyn diclofenac Excedrin Coumadin Plavix fish oil ginko biloba ginseng garlic Excedrin Alka-Seltzer

Allergies to Medications □ None □ Yes (List medication and how you react): _____

_____

Have you had any problems with locally injected anesthesia (Novocaine/Xylocaine) such as that which you may have received at the dentist?	□ No	□ Yes
If yes, what was the reaction?_____		
Are you allergic to latex?	□ No	□ Yes
Do you have a tendency to bleed or bruise easily?	□ No	□ Yes
Have you ever had cold sores or fever blisters on the lips?	□ No	□ Yes
Have you ever healed with skin darkening following minor cuts, abrasions, or trauma?	□ No	□ Yes
Are you now suntanned compared with your skin tone during winter months?	□ No	□ Yes
Are you taking or have you taken Accutane in the past?	□ No	□ Yes
Have you ever had radiation therapy on the face for a cancer or other condition?	□ No	□ Yes
Do you have a history of facial trauma or facial surgery?	□ No	□ Yes
Do you have either upcoming or recent dental surgery?	□ No	□ Yes
Do you have a history of hepatitis or HIV?	□ No	□ Yes
Have you had difficulty with wound healing, abnormal scarring or keloids?	□ No	□ Yes
Female patients: Are you pregnant or planning a pregnancy?	□ No	□ Yes
Are you lactating?	□ No	□ Yes

Thank you for completing this questionnaire. Please sign: ✗ _____

For office use only:

R/B/A disc, pamph/info disp, est. costs disc (circle)
Sunblock / RA/AHA / HQ / 5-FU / chem peel [SA, GA, LHA, TCA (cross)], camofl makeup
ALA/Blu-U, IPL, Nd:YAG, G-YAG, V-Beam, Alex (LHR), Fraxel, Erbium,
Cosmoderm/plast, Juvederm ultra/plus, Restylane, Perlane, Radiesse, Sculptra
Botox, sclerotx, LN, surgery
Other:
Handouts disp.
□ Sun safety
□ Renova/retinoid use
□ Approach to Aging Skin