NCPS

NORTHERN CENTER FOR PLASTIC SURGERY

Skin Consultation Form

Name: _____ Date: _____

Address: _____ Home phone: _____

City: _____State: _____Zip: _____ Business Phone: _____

Date of birth: _____ Cell phone: _____

Email: _____

Single: ☐no ☐yes Married: ☐no ☐yes If yes, anniversary date: _____

Referred By: _____

Medical Information:

Diabetes	Epilepsy	Heart Disease	Pacemaker	Hemophiliac
Pregnant	Virus	Cortisone	Circulatory Disorder	I.U.D.
Anticoagulants	Hypertension	Hormonal Treatment	Glandular Disorder	Metallic Implants

Skin Disease:

Are you pregnant or lactating? Yes No Are you prone to herpes outbreaks? Yes No

Please list all medications you are taking internally, including Accutane (and when last taken):

Please list any medications that you regularly use topically, include Retin-A, AHA's:

Please list any allergies or allergic reactions: _____

How much sun exposure to you receive? A lot Average Minimal

Do you suffer from any of the following?

Milia	Acne (where): _____	Rosacea	Psoriasis
Age Spots	Hyerpigmentaton	Hypopigmentation	Moles
Warts	Broken Capillaries	Eczema	

Have you ever experienced the following? In the last month? No Yes

Professional Peels	Waxing (where):_____	Jessner's Peels
Glycolic Peels	TCA Peels	Laser Hair Removal
Salicylic Peels	Medical Dermabrasion	Microdermabrasio

What would you like to achieve from your treatment today? _____

Your skin care

Which of the following best describes your skin type? (Please circle one type number)

1	creamy complexion	always burns easily, never tans
II	light complexion	always burns, tans slightly
III	light/matte complexion	burns moderately, tans gradually
Iv	matte complexion	seldom burns, always tans well
V	brown complexion	rarely burns, deep tan
Vi	black complexion	never burns, deeply pigmented

What skin care products are you currently using?
(LIST BRAND WHERE KNOWN)

Soap _____
Shower Gels_____
Toner _____
Body_____
Lotions_____
Mask _____
Sunscreen_____
Eye Product _____
SPF _____

Cleanser _____
Night Moisturizer/Cleanser_____
Day Moisturizer _____
Exfoliator _____
Makeup Products_____
Scrubs _____
Other _____

What areas of concern do you have regarding your:
Skin: (Please check any that apply and explain)

☐ Breakouts/acne
☐ Broken Capillaries
☐ Blackheads/whiteheads
☐ Sun Damage
☐ Excessive Oil/ shine
☐ Wrinkles/fine lines
☐ Rosacea
☐ Flaky Skin
☐ Redness
☐ Dehydrated
☐ Sun spot/brown spot
☐ Dull/dry skin
☐ Uneven skin tone
☐ Other
_____

Are you enrolled in a Section 125 Health Savings Account (HAS), Flexible spending Account (FSA) or Health Reimbursement Account (HRA)? Yes No

I hereby certify to the best of my knowledge that the answers I have given are correct. I also do not have any medical condition(s) or received advice from my medical provider that would prevent me from receiving the treatments I have selected. Furthermore, I agree to hold harmless Northern Center For Plastic Surgery from any and all liability relating to any injury that may sustain as a result of having the aforementioned medical condition(s).

Signature: _____ Date: _____