SKINovative® & CENTER FOR Venous Disease
Innovative skin & body care. Beautiful results.

2557 S. Val Vista Drive, Suite 101, Gilbert, AZ 85295
480-917-SKIN (7546)
GilbertMedSpa.com

Today's Date: ____/____/____ Name of Consultant: _____

Name: _____ Female/Male (please circle) **Birth Date:** ____/____/____

Address: _____ City: _____ ST: _____Zip: _____

Home Phone: _____ Cell Phone: _____ **E-MAIL**:_____

May We Contact You For Appt. Confirmations, etc.? _ Y_ N Employer: _____ Occupation: _____

Marital Status: Single / Married / Widowed (please circle) Wedding Anniversary: ____/____/____

Is Partner Supportive of Your Potential Treatment? Yes / No / Doesn't Know I'm Here (please circle)

Ethnic background (three generations back): _____

How did you hear about us? (Please be specific): _____

Skinovative of Gilbert has many cosmetic treatment options available. To better serve you, please describe the **main reason** for today's consultation: _____

Please explain how the problem affects you, and why you've decided to seek treatment now. _____
_____

What is important to you when deciding on a treatment? _____

Please fill out to the best of your ability. All information will be held in strict confidence.

I. **MEDICAL HISTORY**
Are you allergic to or have you ever had a reaction to any of the following? ☐ Medication (prescription or over the counter) ☐ aspirin ☐ latex ☐ 'cillin' medications ☐ 'caine' medications ☐ food ☐ fragrance ☐ cosmetics ☐ pollen ☐ animals
Please specify:
_____

Illnesses (past five years): _____ Chronic problems: _____

Surgery, (incl. cosmetic): _____ Do you faint easily? ☐Y ☐N
Do you scar easily? ☐Y ☐N

Do you have any of the following?	Heart disease ☐Y ☐N	Epilepsy ☐Y ☐N	Hepatitis ☐Y ☐N
High Blood Pressure ☐Y ☐N	Thyroid Condition ☐Y ☐N	Herpes ☐Y ☐N	Lupus ☐Y ☐N
Hormone Imbalance ☐Y ☐N	Immune Disorder ☐Y ☐N	Cancer ☐Y ☐N	Diabetes ☐Y ☐N
Systemic Disease ☐Y ☐N	Cold sores ☐Y ☐N	Migraines ☐Y ☐N	HIV ☐Y ☐N

If yes, please explain: _____

Do you have a history of any neurological diseases? i.e. (Myasthenia Gravis) ☐Y ☐N
If yes, please specify: _____ Do you have metal implants or a pacemaker? ☐Y ☐N

Do you have any medical conditions requiring medication? ☐Y ☐N please specify condition: _____
Please list any prescribed or over the counter oral medications you are currently using, including: allergy medications, Aspirin, acne treatments, Ibuprofen, herbs & vitamins:
_____

Are you currently seeing a dermatologist? _____Any diagnosed condition(s)? ☐Y ☐N
please specify condition: _____

For women only: Birth Control Pills ☐Y ☐N Menopausal/Peri-Menopausal HRT? ☐Y ☐N
Breakouts related to cycle? ☐Y ☐N Depo-Provera ☐Y ☐N Date of last shot: ___/___/___
Pregnant ☐Y ☐N Pregnant Due date: ___/___/___ Nursing ☐Y ☐N

Please describe your skin and skin concerns by checking all that apply:

___ Thick	___ Dry	___ Active Acne	___ Sallow
___ Thin	___ Normal	___ Acne Scars/Scars	___ Puffiness
___ Saggy	___ Oily	___ Blackheads/Whiteheads	___ Rosacea
___ Firm	___ Combination	___ Cysts	___ Sun Damaged/Freckles
___ Fine lines	___ Large Pores	___ Dark spots/Patches	___ Eczema or Psoriasis
___ Wrinkled	___ Dehydrated	___ Scaling/Flaking	___Dark Circles/Eyes
___ Aging	___ Uneven/Blotchy	___ Broken Capillaries	Other_____

GENERAL HEALTH QUESTIONS

Do you have regular sleep patterns? ☐ Yes ☐ No
Do you follow a restricted diet? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No
Do you wear contact lenses? ☐ Yes ☐ No
What is your pain threshold? ☐ Low ☐ Medium ☐ High
Have you ever-experienced claustrophobia? ☐ Yes ☐ No
Do you drink caffeinated beverages (coffee, tea, soft drinks)? ☐ Yes ☐ No How many daily? _____
Do you drink alcohol? ☐ Yes ☐ No How often? ☐ Daily ☐ Weekly ☐ Monthly

SKIN CARE

Would you describe your skin as sensitive or reactive? (Please circle one)
Do you experience irritation from shaving? ☐ Yes ☐ No Do you experience ingrown hairs? ☐ Yes ☐ No
For unwanted hair do you ☐ wax, ☐ tweeze or ☐ shave?
What SPF sunscreen do you use on your face? _____ Body? _____

Do you sunbathe? ☐ Yes ☐ No Tan in a Professional Salon? ☐ Yes ☐ No Within last 6 weeks? ☐ Yes ☐ No
What skin care products are you currently using? ☐ Soap ☐ Cleanser ☐ Toner ☐ Moisturizer ☐ Masque ☐ Exfoliator ☐ Eye Products ☐ Sunscreen ☐ Shaving products ☐ Prescription skin care product ☐ Acne products ☐ Foundation ☐ Skin lighteners ☐ Others: _____
What brand name(s) to do you use?
_____

Have you ever had a reaction to any of the following cosmetic ingredients? ☐ Progesterone ☐ Aloe Vera ☐ Hydroquinone ☐ Benzoyl Peroxide ☐ Sulphur ☐ Glycolic ☐ Cortisone ☐ Vitamin C (L-Ascorbic Acid) ☐ Sunscreens ☐ Other _____

CAPILLARY ACTIVITY

Do you burn in moderate sunlight: ☐ Easily ☐ Moderately ☐ Never
Do you blush easily when nervous? ☐ Yes ☐ No
Do you have a tendency to redness? ☐ Yes ☐ No

MOISTURE HYDRATION

How much plain water do you consume daily? _____
Do you ever experience these conditions on your skin? ☐ Tightness ☐ Flakiness or Peeling ☐ Obvious Dryness

OIL SECRETION

Do you ever experience oily shine during the day? ☐ Yes ☐ No
Do you ever experience skin breakouts? ☐ Yes ☐ No ☐ Occasionally

EXFOLIATION HISTORY

Have you ever had chemical peels, laser or microdermabrasion? ☐ Yes ☐ No In the last year? ☐ Yes ☐ No
Do you use Retin-A, Renova, Differin, Adapalene or Retinol? ☐ Yes ☐ No In the last 6 months? ☐ Yes ☐ No
Do you use an Acne Medication? ☐ Yes ☐ No In the last 6 months? ☐ Yes ☐ No If yes, which drug: _____
Are you currently using products that contain the following ingredients?

☐ Glycolic Acid ☐ Lactic Acid ☐Vitamin A Derivatives (Retin A)
☐ Exfoliating scrubs ☐ Hydroquinone ☐ Salicylic Acid

Additional Notes:

_____
_____
_____

Patient Signature: _____ Date: _____

Medical Director: _____ Date: _____