Skincare History Questionnaire

Patient Profile & Waiver

Last Name_____First_____Middle_____

Birthdate_____Address_____

City_____State_____Zip_____Cell #_____Work Ph_____

PATIENT PROFILE HISTOLOGY

Allergies: (Do you have allergies to any of the following? Check all that apply.)

❑ Aspirin	❑ Hydroquinone	❑ Salicylic Acid	❑ Beta hydroxyacids
❑ Hydrogen Peroxide	❑ Benzoyl Peroxide	❑ Retin-A	❑ Sunblock

Ingredients in skincare products ❑ Yes ❑ No

If yes, write allergies on this line

_____

❑ No allergies to any of the above

Are you currently using any antioxidant supplements?	❑ Yes	❑ No
Are you currently using any Retin-A?	❑ Yes	❑ No
Are you currently using any Accutane?	❑ Yes	❑ No
Do you smoke?	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No
Attempting pregnancy?	❑ Yes	❑ No
Are you receiving hormone therapy?	❑ Yes	❑ No
Are you being treated for herpes simplex?	❑ Yes	❑ No

AREAS OF CONCERN

- ❑ I have environmentally damaged skin
- ❑ I have occasional acne
- ❑ I have deep cystic acne
- ❑ I have dry skin with acne breakouts
- ❑ I have large pores
- ❑ I have scarring
- ❑ I have brown spots
- ❑ I have redness or rosacea
- ❑ I have broken capillaries
- ❑ I have dehydrated skin
- ❑ I have combination skin, dry in some places, oily in the T zone
- ❑ I have oily skin all over my face
- ❑ I have lines and wrinkles from natural aging
- ❑ I have no special skin problems
- ❑ Other: _____

❑ I am interested in laser hair removal of the following areas and what color is the hair to be removed?:

_____

_____

UMG Plastic Surgery & Aesthetics
200 Patewood Dr., Suite B480, Greenville, SC 29615 ● (864) 454-4570 ● (864) 454-4575 Fax
www.umgplasticsurgery.com

LIST THE RESULTS THAT YOU ARE WANTING TO ACHIEVE:

_____

_____

HOME SKINCARE PRODUCTS

Cleanser_____ Times/day_____ Toner/Astringent_____

Moisturizer_____ Eye cream_____ Exfoliants/Scrubs_____

Sunscreen use_____ Other_____ Make-up_____

I would like to receive discounts for services/products. Email to:_____

Please tell us how you heard of us: _____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge.

I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s).

I understand that hair removal requires multiple treatments. Results vary depending on prescriptive medicines and individual condition(s) and may require more than 5 treatments. Package pricing includes 5 treatments only.

I understand that all sales are final as there is a **"NO REFUND"** policy on all products and services.

Client Signature:_____ Date:_____

DO NOT COMPLETE BELOW THIS LINE

PATIENT SKIN ANALYSIS (DO NOT COMPLETE)

❑ Acne - Type:_____ ❑ Scars

❑ Comedones:_____

❑ Enlarged pores:_____

❑ Elastosis:_____

❑ Keloids:_____

❑ Keratosis:_____

❑ Milia:_____

❑ Pigmentation:_____

❑ Rosacea/Redness:_____

❑ Wrinkles ❑ Fine ❑ Deep:_____

MAIN CONCERN:_____

Photo taken ❑ Yes ❑ No

❑ Oily ❑ Dry ❑ Normal ❑ Combination

❑ Thick ❑ Thin ❑ Normal

HAIR REMOVAL:_____

_____

_____

_____

_____

_____

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