ASTHETIC AND COSMETIC DERMATOLOGY
AT
WHITE SALMON FAMILY PRACTICE

CLIENT INFORMATION QUESTIONNAIRE AND INFORMED CONSENT

By signing this consent form, you are agreeing that you have been informed of known risks, benefits and alternatives related to receiving your chosen cosmetic treatment(s).

PLEASE NOTE: IF YOU HAVE A SPECIAL EVENT PENDING WITHIN THE NEXT 2 WEEKS PLEASE DISCUSS WITH US. BRUSING AND SWELLING CAN OCCURE!!

Please answer the following questions thoroughly and completely as this provides a better understanding of your general health, lifestyle, and skin care concerns, thereby enabling the best treatment and home care recommendations.

DEMOGRAPHICS

Name: _____ Date: _____

MAILING Address:
_____

City: _____ State: _____
Zip:_____

Occupation:
_____
_____
_____

Home Phone: _____ Cell Phone: _____

May we call you on either phone:
_____
May we leave messages on either phone:
_____

Email:
_____
_____

Date of birth (month and day and year): _____

Let us thank the person who referred you:
_____

Skin Care History

If there was something you could change or improve about your skin, what would it be?
_____
_____
_____

What else? Please circle all that apply.

Discoloration (Brown Spots or Melasma)
Acne Scarring Uneven Texture
Fine Lines & Wrinkles
Enlarged Pores Sun Damage
Dry, Flaky Skin
Rosacea
Loss of Facial Contours
Oily Skin
Dilated Capillaries
Lax or Sagging Skin
Acne/Breakouts Redness (Reactive Skin)
Dark Under-Eye Circles

What type of skin do you think you have?
Dry: _____ Normal: _____ Combination: _____ Oily: _____

If oily, are you oily throughout the cheek area? Yes: _____ No: _____

Do you have a history of acne? Yes: _____ No: _____
If yes, are you using or have you ever used any medications for acne? Yes: _____ No: _____
Name of medication:
_____
_____

Do you sunbathe or participate in outdoor activities? Yes: _____ No: _____

Have you ever had a reaction to any skin care product or cosmetic? Yes: _____ No: _____

If yes, please list:

_____

_____

_____

What skin care do you currently use?

Morning	EVENING
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Are you a member of Allergan Brilliant Distinctions? _____ Do you know your log-in information or number:

_____

_____

Please circle any medications you are currently using or have used in last year:

Retinol Benzoyl Peroxide (BPO) Adapalene (Differin®)
Glycolic Acid Hydroquinone Azelaic Acid (Azelex®, Finacea®)
Salicylic Acid Tretinoin Isotretinoin (Accutane®)
Citric Acid Topical Antibiotics
Resorcinol Topical Steroids

Have you ever, or are you currently receiving skin treatments? Yes: _____ No: _____

Have you had any of the following? (Circle all that apply):

Chemical Peels Permanent Cosmetics Extractions
Laser Resurfacing Light Treatments Electrolysis
Facial Cosmetic Surgery Microderm Abrasion Laser Hair Removal
Facial Injectibles Dermaplanning Waxing

If yes, when was your last treatment(s)?

_____

_____

_

Were there any complications? Yes: _____ No: _____
If yes, please explain:
_____
_____

General Health

Are you currently under the care of a physician?
_____

If yes, please discuss contraindications of any pre-existing medical conditions with your physician.

Are you currently taking any medications? Yes: _____ No: _____

If yes, please list here:
_____
_____
(or on the back of this page) Please let us know if you take multiple medications and feel the list is to lengthy to itemize

Female Clients
Are you on hormone-replacement therapy? Yes: _____ No: _____

Are you on birth control pills? Yes: _____ No: _____

Are you pregnant or breastfeeding? Yes: _____ No: _____

Please circle all of the following conditions you have, or have had, in your facial, scalp or chest areas:

Dermatitis Cold Sores or Fever Blisters
Eczema Actinic Keratosis
Psoriasis Keloid Scarring
Open Sores or Lesions

Are you allergic to aspirin? Yes: _____ No: _____

What is your pain tolerance?

_____
_____

If you have any known allergies, please list them:
_____

Is there anything else that should be known before starting your treatment?:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
Date Signature

Reviewed By: _____ Date:
_____

Comments: (Staff only)
_____
_____
_____
_____
_____
_____