NorCal Dermatology and Cosmetic

Cosmetic Questionnaire

1111 Sonoma Ave. Suite #202 Santa Rosa CA, 95405 **P**: 707.527.9517 **F**: 707.527.9913
1165 South Dora, Suite #G2, Ukiah CA, 95482 **P**: 707.462.2960 **F**: 707.462.2756

Patient Name ____ Date ______________
First Last

Address: ____

Phone: ______________ Mobile: ______________ Email: __________________________

D.O.B ____________ Gender: **[ ] Male [ ] Female** Marital Status: **[ ] S [ ] M [ ] D [ ] W**

RACE: [ ] White [ ] Hispanic [ ] Asian [ ] Black/African American
[ ] American Indian or Alaska Native [ ] Hawaiian or Pacific Islanders [ ] other: _______

LANGUAGE: [ ] English [ ] Spanish
[ ] other ________

What is/are the main reason(s) you came in for this consultation? ____________________________________

____

Please check any areas you would like to discuss or receive more information about:

- ☐ Botox/Dysport
- ☐ Restylane/Perlane
- ☐ Sculptra
- ☐ Chemical Peels
- ☐ Lip Augmentation
- ☐ Laser Treatments
- ☐ Excessive Hair growth

- ☐ Wrinkles
- ☐ Freckles/Brown Spots
- ☐ Facial red vessels
- ☐ Leg Spider Veins
- ☐ Mouth/Lips Lines
- ☐ Frown Lines
- ☐ Rosacea/red complexion

- ☐ Liver Spot/Age spots
- ☐ Sun Damage
- ☐ Dry rough skin
- ☐ Skin Care Regimen
- ☐ Skin Care Products
- ☐ Other: __________

What cosmetic treatments and procedures, if any, have you had in the past? ______________________________

____

If you have previously had any cosmetic treatments or procedures, were you pleased with the outcome?
[ ] Yes [ ] No If no, what was the procedure and in what way were you dissatisfied?

____

____

Which of the following best describes your skin type and natural hair color?

1. Always burns, never tans
2. Sometimes burns, always tans
3. Brown moderately pigmented
4. Always burns, sometimes tans
5. Rarely burns, always tans
6. Black Skin

Hair Color
- ☐ Black
- ☐ Brown/Light/Dark
- ☐ Blonde/Light/Dark
- ☐ Red
- ☐ White/Grey

Do you have permanent make-up or tattoos anywhere? [ ] Yes [ ] No

Do you sunbathe, or go to tanning salons? [ ] Yes [ ] No

Do you use chemical sunless tanning? [ ] Yes [ ] No

Do you use sunscreen daily? [ ] Yes [ ] No

NorCal Dermatology and Cosmetic

Cosmetic Questionnaire

1111 Sonoma Ave. Suite #202 Santa Rosa CA, 95405 **P**: 707.527.9517 **F**: 707.527.9913
1165 South Dora, Suite #G2, Ukiah CA, 95482 **P**: 707.462.2960 **F**: 707.462.2756

Name: ____ DOB: ____________
First Last

Medical history, please check 'yes' if you have ever been diagnosed with the following:

- ☐ Hepatitis A-B-C
- ☐ HIV/AIDS
- ☐ Cold Sores/ Shingles
- ☐ Anaphylaxis
- ☐ Sun sensitivity disorders
- ☐ Actinic Keratosis
- ☐ Keloid scars
- ☐ Pigmentary disorders

Other illnesses or medical conditions? ____

Autoimmune and neurologic diseases: (please check any that apply)

- ☐ Myasthenia Gravis
- ☐ Eaton-Lambert disease
- ☐ Multiple sclerosis
- ☐ Lupus
- ☐ Scleroderma
- ☐ Other: ____________

Are you allergic to any of the following products/medications? If yes, please describe your reaction______________

____

- ☐ Anesthetic agents
- ☐ Codeine
- ☐ Bleaching agents
- ☐ Latex
- ☐ Tetracycline
- ☐ Hydroquinone
- ☐ Hydrocortisone
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aloe Vera

Please list any allergies not listed above: ____

Are you taking any blood thinners? [ ] Yes [ ] No If yes please list: ______________________

Are you pregnant, nursing, or trying to become pregnant? [ ] Yes [ ] No Do you smoke? [ ]Yes [ ] No

Would you like to receive information about any cosmetic or product discounts? [ ] Yes [ ] No

If our office hosted an event about cosmetic procedures/treatments, would you be interested in attending? [ ] Yes [ ] No

If yes to either of the two questions above, please provide your contact preference: [ ] postal mail [ ]email

I certify that the preceding medical, personal and skin history atatements are true and correct. I am aware that it is my responsibility to inform the provider of my current medical or health conditions and to update this history, as a current medical history is essential for the caregiver to execute appropiate treatment procedures.

Signature ____ Date: ____________