Skin Matters

A Division of Patrick H. Pownell, M.D., PA

Patient Registration

Name_____**Date**_____

Address_____

City _____**State**_____ **Zip**_____

Home Phone _____**Cell Phone**_____

Office Phone_____**E-Mail**_____

May we include you on our newsletter/e-mail list? Yes No

Birthday_____**Referred By**_____

Thank you for choosing Skin Matters for your skincare needs. We will make every effort to assure your session is an enjoyable experience and your results are second to none. **Please review the policies below and initial after each paragraph.**

OFFICE POLICY: As a courtesy to our practice, and your fellow client, please give 24 hours notice if needing to change or cancel an appointment. No-shows or cancellations with less than 24 hours notice will be charged 50% of the full treatment fee.
Initial please _____.

PHOTOGRAPHS: Photographs will be used as documentation only and will not be used for marketing/education unless otherwise agreed to in writing.
Initial please _____.

HOME CARE COMPLIANCE: In an effort to achieve the best clinical results possible, it is highly recommended that professional treatments be followed up with specific home care products according to skin type and condition. I understand that if I choose not to purchase specific treatment products, I may not achieve the results for which I am looking. I also agree to inform the staff at Skin Matters immediately of any concerns, questions or reactions I may have pertaining to the treatments or home care products.
Initial please _____.

I hereby consent to allow the staff at Skin Matters to perform services as deemed necessary for cosmetic improvement, including, but not limited to, microdermabrasion, chemical exfoliation and topical cosmetic therapy.

Signature_____ **Date** _____

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Patient Consultation

1. Have you ever seen a dermatologist for your skin? Yes_____ No_____
If yes, explain _____

2. Are you presently under a doctor's care? _____ Why? _____

3. Are you currently taking or have you ever used: Tranquilizers_____
Antibiotics _____Diuretics_____ Birth control or hormones _____
Antidepressants _____Steroids_____ Allergy Medications _____
Coumadin _____Aspirin_____
List all oral medications you are taking, including OTC drugs: _____
_____

4. List any topical medications (prescription or over the counter) you use or have used:
Acne _____ Retin-A/Renova_____ Glycolic acid _____ Tazorac _____
Differin_____Other_____

5. Do you take vitamins or food supplements? _____List_____

6. Have you ever taken Accutane? _____ When? _____ How long? _____

7. List all medications you are allergic to: _____

8. Have you ever had a skin allergy? _____ Cosmetics _____ Fabrics _____
Aspirin_____ Rashes _____Other_____ Explain_____

9. Do you have a history of Chronic Acne_____ Chronic Skin Sensitivity _____
Explain _____

10. Have you ever had an adverse reaction after using a skin care regimen? _____
If yes, describe (rash, irritation, peeling, sensitivity, etc.)_____
_____

11. **For ladies only**: Are you pregnant or lactating? Yes_____ No_____
Do you have regular periods? _____ Are you going through menopause? _____
During pregnancy, did you get hyperpigmentation or masking? _____

12. Do you smoke? _____ How much? _____

13. Do you consume alcohol? _____ How much? _____

14. Do you have a history of acne or periodic breakout? _____
Pimples_____ Cysts_____ Whiteheads_____ Blackheads _____
Enlarged pores _____ Acne scars _____ Hormone related_____
Frequency_____

15. Is your skin: Dry_____ Combination_____ Oily_____ Acne Prone_____

16. Does your skin appear fragile or burn easily? Yes _____ No _____

17. Do you form a thick or raised scar from a cut or burn? Yes _____ No _____

18. Do you wax or use depilatories on your face? Yes _____ No _____ Frequency _____

19. Do you have a history of cold sores? Yes _____ No _____ Frequency _____
Have you had any active lesions in the last 4-6 weeks? _____

20. Have you ever had chemotherapy or radiation? Yes _____ No _____
Please explain_____

21. I certify that I am not HIV positive, have AIDS or Hepatitis C. *(Initial, please)*_____

22. Have you had facial surgery, facial peels, laser surgery, microdermabrasion, recent Botox or Restylane? Yes_____ No _____ When _____

23. Have you or any member of your family had skin cancer? Yes _____ No _____
Anatomical location _____

24. Are you active outdoors? _____Explain_____
In the past, have you neglected to use sunscreen when outdoors? Yes _____ No_____

25. Do you use **daily** sun protection? Yes _____ No _____ SPF_____

26. Do you or have you ever-used tanning beds? Yes _____No _____ Frequency_____

27. What is your ethnic background?_____

28. Describe your daily skincare routine: A.M._____
_____ P.M.
_____

29. Do you wear contact lenses? Yes _____No_____

I hope to achieve the following results (check all that apply): Diminish fine lines_____
Control acne_____ Smooth skin texture_____ Shrink enlarged pores_____
Even pigmentation _____ Reduce scarring_____Other_____

The areas I would like most to improve are: Around the eyes _____ Cheeks _____
Neck _____ Around the mouth _____ Forehead _____ Hands _____ Chin _____
Browline _____ Chest _____ Arms _____ Other _____

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Signature _____ Date _____