PARTINGTON
PLASTIC SURGERY CENTER

SKIN CARE PROFILE

Name: _____ Date of Birth: _____

Primary Phone Number:_____ Alternative Phone Number:_____

Address: _____City:_____State:_____Zip: _____

E-Mail:_____Occupation:_____

Emergency Contact: _____Phone Number:_____

How did you hear about us? _____

Would you like to be contacted for special promotions? Please Check One: Yes_____ No_____

If yes, please state the best way to contact you. E-Mail Mail Phone

Skin Care History Please circle:

When you are exposed to sun, do you:	Tan Only	Tan and Burn	Always Burn
Have you ever had skin cancer?		Yes	No
If yes, was it Melanoma?		Yes	No
Has anyone in your family had skin cancer?		Yes	No
If yes, who: _____ Was it Melanoma?		Yes	No
Do you have any specific skin diseases?		Yes	No
If yes, please list: _____			
Have you taken Accutane or Anticoagulants in the last 6 months?		Yes	No
Are you currently using Retinoids or topical exfoliants?		Yes	No
Are you currently using Glycolic Acid or other AHA's?		Yes	No
Do you scar easily?		Yes	No
Do you currently wear a Full Spectrum Sunblock?		Yes	No
If so, what brand? _____			
Do you have permanent make-up, implants, or tattoos?		Yes	No
Do you bruise easily?		Yes	No
Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last four to six weeks?		Yes	No
Have you ever had cosmetic surgery, a chemical peel, or other treatment?		Yes	No
If yes, where and when? _____			

Please list you current skin regimen: _____

_____

_____

Please list concerns about your skin that you would like to address: _____

_____

_____

Medical History

Please list all allergies _____

Are you currently under a doctor's care? If so, why _____

_____

Are you taking any prescription medications? Yes No

If yes please list with frequency _____

Signature_____Date_____