

PATIENT ASSESSMENT PROFILE

Today's Date: _____

NAME: _____ SEX: MALE ____ FEMALE ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: _____ MOBILE: _____

DATE OF BIRTH: _____ NATIONALITY: _____

(The following information is necessary to evaluate and meet your individual needs for professional service and home care maintenance. All information is confidential.)

1. Skin care questions:

What three things would you like to change about your skin?

A. _____

B. _____

C. _____

2. Have you been seen by a dermatologist/Plastic surgeon? Yes ____ No ____

If so, for what reasons? _____

3. Please list all medications that you take regularly. Include hormones, Vitamins etc.

A. _____

B. Are you or have you taken accutane? Yes ____ No ____

If yes, for how long. _____

C. Do you use Retin-A, Renova, Tazorac, Avita, Differin or Tretinoin?

If yes for how long and when? _____

4. Do you have any medication or skin related allergies? Yes ____ No ____

If yes please list allergies: _____

5. Are you pregnant or lactating? Yes ____ No ____

6. Have you had any of the following procedures?

Date

Laser Resurfacing	Yes _____ No _____
Light Chemical Peel	Yes _____ No _____
Medium/heavy Chemical peel	Yes _____ No _____
Botox	Yes _____ No _____
Collagen, Restylane, Sculptra or other fillers	Yes _____ No _____
Implants such as Soft Form	Yes _____ No _____
Cosmetic/reconstructive Surgery	Yes _____ No _____

7. Professional Analysis- Oil Secretion level.

A. How does your face feel upon awakening?

Oily _____ Dry/itchy _____ Normal _____

B. After cleansing your face in the morning, how soon do you notice an oily shine?

Before noon _____ Noon to 3PM _____ After 3p.m _____ Not at all _____

C. Do you ever experience skin breakouts? Yes _____ No _____

8. General Nerve Activity level.

A. Do you suffer from or have you experienced claustrophobia? Yes _____ No _____

B. Do you prefer massage pressure to be: Light _____ Medium _____ Firm _____

C. Have you ever had a reaction to any of the following?

Cosmetics Yes _____ No _____

Metals Yes _____ No _____

Foods Yes _____ No _____

Animals Yes _____ No _____

Pollen Yes _____ No _____

Contra-Indications/Comments: _____

9. Lifestyles Questions:

A. Please indicate the foods you consume: L-light M-moderate H-heavy

- | | | | | |
|------------------------------------|------------------------------------|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Rice | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Chips | <input type="checkbox"/> Water/Tap |
| <input type="checkbox"/> Yogurt | <input type="checkbox"/> Beans | <input type="checkbox"/> Red Meats | <input type="checkbox"/> Sodas | <input type="checkbox"/> Water/Bottle |
| <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Cereals | <input type="checkbox"/> Chicken | <input type="checkbox"/> Coffee/reg | <input type="checkbox"/> Juices/fresh |
| <input type="checkbox"/> Butter | <input type="checkbox"/> Nuts | <input type="checkbox"/> Turkey | <input type="checkbox"/> Coffee/dec | <input type="checkbox"/> Juices/Bottle |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Grains | <input type="checkbox"/> Fish | <input type="checkbox"/> Tea/reg | <input type="checkbox"/> Tea/Herbal |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Bread | <input type="checkbox"/> Sweets | <input type="checkbox"/> Fruits | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Chocolate | | | |

B. How many hours do you sleep per night? _____

C. Do you participate in vigorous aerobic activities or sports? Yes ___ No ___

D. Do you smoke? Yes ___ No ___

(Smoking promotes free radical formation which causes collagen breakdown. Excessive smoking will make it more difficult to attain and maintain results.)

10. Please check any health conditions you have had or are now experiencing:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Metabolic Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Silicone/Filler Injections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Intestinal problems |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Other | | |

11. Skin Moisture/Hydration level:

Do you even experience tightness or flaking of your skin? Yes ___ No ___

12. Do you frequent tanning booths? Yes ___ No ___

13. Do you have a history of fever blisters or cold sores? Yes ___ No ___

14. Have you ever received a facial/body treatment? Yes ___ No ___

15. What is your home skincare routine? Please include brand names.

	AM	PM
Cleanser	_____	_____
Toner	_____	_____
Topical (Glycolic, Vitamins C)	_____	_____
Moisturizer	_____	_____
Eye Cream	_____	_____
Sun Block	_____	_____
Exfoliant, Mask	_____	_____
Other	_____	_____

16. Do you use Sun block daily on a year round basis? Yes ___ No ___

If Yes, What Strength? _____

17. What are your skincare concerns?

___ Sun Damage	___ Clogged pores
___ Brown Spots (uneven tones)	___ Excessive Oiliness
___ Upper Lip Lines- Deep () or Fine ()	___ Acne
___ Blackheads	___ Whiteheads
___ Pimples- Often () or () Sometimes	___ Dry Patches
___ Hard bumps under Skin	___ Freckles
___ Wrinkles- Deep () or () Fine	___ Scarring
___ Visible exposed Blood Vessels	___ Ingrown Hair
___ Unwanted Hair	___ Other

18. Do you wear contact lenses? Yes ___ No ___

(If yes, please remove contacts prior to any procedure to avoid eye irritation)

19. How did you hear about us?

___ Friend- Name of friend: _____

___ Doctor referral- Name of Doctor: _____

___ Advertising –Newspaper etc: _____

INFORMED CONSENT

I _____, consent to and authorize Dr. Virgil Hatcher or Licensed Members of his staff to perform microdermabrasion, chemical peel and/or any other aesthetic skin care services. The nature and purpose of the treatment has been explained to me and any questions I have regarding this procedure have been explained to my satisfaction.

- ❖ I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks.
- ❖ Possible side effects include, but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infection, pimples, bumpy appearance, cold sores and rarely scarring. Most side effects are temporary and generally subside within 72 hours.
- ❖ If I am prone to herpetic outbreaks (e.g. Cold sores, fever blisters) I have been advised to notify my physician.
- ❖ I have been advised to discontinue all AHA's, Glycolics, Retin-A, Renova or any exfoliating products for up to 72 hours post procedure. I understand that I must use hydrating and soothing ointments for healing, and ice for swelling and inflammation reduction. Also I understand there should be no sun exposure for 72 hours and the use of an SPF 30 at all times during treatment duration is advised.
- ❖ I have been advised to avoid collagen injections, Botox, chemical peels and any cosmetic procedures at least 3 days prior to microdermabrasion treatment and for at least one week post-treatment and agree to these restrictions.
- ❖ I agree to adhere to all safety precautions and home skin care program as recommended by my physician.
- ❖ I am over 18 years of age or I have parental consent co-signed below.
- ❖ I will call to inform my physician of any complications or concerns I may have as soon as they occur.

By providing my signature below I acknowledge that I have read and understood all of the information. I hereby freely consent to the services performed by the licensed member of Dr. Virgil Hatcher's staff and authorize the taking of clinical photographs which will be used solely for my medical records unless my physician deems their anonymous use (in lectures or scientific publications) could benefit research and education.

Patient's or Guardian's Signature:

_____ Date: _____

Witness' Signature:

_____ Date: _____