

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Sex/Gender: M F Intersex Transgender  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
 Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_  
 Email: \_\_\_\_\_ Preferred Gender Pronoun: \_\_\_\_\_  
**Allergies:** \_\_\_\_\_ Profession \_\_\_\_\_  
 How did you hear about SkinMD? \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

**Please put a check mark next to a past or current medical condition:**

\* *may alter wound healing*

- |  |  |
|--|--|
| <input type="checkbox"/> *Lupus or other autoimmune deficiency                   | <input type="checkbox"/> Herpes simplex or fever blisters        |
| <input type="checkbox"/> Thyroid dysfunction (Hyper or *Hypo thyroid)            | <input type="checkbox"/> *Diabetes                               |
| <input type="checkbox"/> *Bleeding disorder/ Bruise easily                       | <input type="checkbox"/> Epilepsy/ Seizure Disorder              |
| <input type="checkbox"/> Treatment with Accutane ® in the last year              | <input type="checkbox"/> Scars that turn white or brown          |
| <input type="checkbox"/> Treatment with Minocin/Tetracycline ® in the last month | <input type="checkbox"/> Dark spots after pregnancy, skin injury |
| <input type="checkbox"/> Keloid or very thick scarring                           | <input type="checkbox"/> HIV/ AIDS                               |
| <input type="checkbox"/> Psoriasis or Vitiligo                                   | <input type="checkbox"/> Hepatitis                               |
| <input type="checkbox"/> Pulmonary embolism/blood clot                           | <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)        |
| <input type="checkbox"/> Leg ulcer or Phlebitis                                  | <input type="checkbox"/> Hirsutism                               |
| <input type="checkbox"/> Alopecia/ Hair Loss                                     | <input type="checkbox"/> Transplant Anti-Rejection Drugs         |
| <input type="checkbox"/> *Coumadin or anti-clotting/blood thinning Rx            | <input type="checkbox"/> Rheumatoid Arthritis "Gold" Therapy     |
| <input type="checkbox"/> Cystic Acne   | <input type="checkbox"/> Eczema/Skin Diseases                    |
| <input type="checkbox"/> Cancer; if yes, what type? _____                        | <input type="checkbox"/> Other: _____                            |

If history of Herpes/Fever Blister/Shingles Date of Last Outbreak \_\_\_\_\_ (With + Hx. of herpes – Start pt. on Valtrex 500mg. BID 2 days pre & 3 days post tx.)

Rx Written/Called in to \_\_\_\_\_ Date \_\_\_\_\_ Pharmacy # \_\_\_\_\_

**Please list ALL medications or herbal supplements that you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you undergone any surgery recently (past 5 years)? Y N: \_\_\_\_\_

Do you have pacemaker/ metal stent/ metal implants in your face or body? Y N: \_\_\_\_\_

Do you exercise regularly? Y N: \_\_\_\_\_

What is your average night's sleep? \_\_\_\_\_

Do you smoke? Y N If yes, # packs/day: \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Are you pregnant or trying to become pregnant? Y N Are you currently breast-feeding? Y N

Are you on Birth Control Pills / Patch / HRT? Y N Perimenopausal/Menopausal/Postmenopausal Y N

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**What is your daily consumption of:**

Water \_\_\_\_\_oz. Coffee\_\_\_\_\_oz. Tea\_\_\_\_\_oz. Soda/Pop\_\_\_\_\_oz. Alcohol\_\_\_\_\_oz. Red Bull\_\_\_\_\_oz.

**What water temperature do you cleanse with?** \_\_\_\_\_Cold \_\_\_\_\_Warm \_\_\_\_\_Hot

**Any special skin concerns?**

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Oily         | <input type="checkbox"/> Dry                    | <input type="checkbox"/> Sensitive         |
| <input type="checkbox"/> Flaking      | <input type="checkbox"/> Breakouts/Acne         | <input type="checkbox"/> Scarring          |
| <input type="checkbox"/> Dry Patches  | <input type="checkbox"/> Uneven Pigmentation    | <input type="checkbox"/> Redness           |
| <input type="checkbox"/> Pores        | <input type="checkbox"/> Melasma                | <input type="checkbox"/> Texture           |
| <input type="checkbox"/> Wrinkles     | <input type="checkbox"/> Facial Veins           | <input type="checkbox"/> Sun Damage        |
| <input type="checkbox"/> Moles        | <input type="checkbox"/> Spider Veins/Leg Veins | <input type="checkbox"/> Unwanted Hair     |
| <input type="checkbox"/> Dark Circles | <input type="checkbox"/> Rosacea                | <input type="checkbox"/> Crepiness/ Laxity |

**What is your current skin care routine?**

- |                                    |                                   |                                       |
|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Soap      | <input type="checkbox"/> Cleanser | <input type="checkbox"/> Toner        |
| <input type="checkbox"/> Scrub     | <input type="checkbox"/> Masque   | <input type="checkbox"/> Moisturizer  |
| <input type="checkbox"/> Sunscreen | <input type="checkbox"/> Serum    | <input type="checkbox"/> Other: _____ |

**What brand(s) of skincare do you use:** \_\_\_\_\_

**What facial/skin treatments have you had?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Filler (Radiesse/Juvederm/Belotero/ Bellafill etc.) | <input type="checkbox"/> Botulinum Toxin (Botox/Dysport/Xeomin/Jeuveau) |  |
| <input type="checkbox"/> Laser Hair Removal                                  | <input type="checkbox"/> Laser Vein Removal                             | <input type="checkbox"/> Chemical Peels                  |
| <input type="checkbox"/> IPL/PhotoFacial                                     | <input type="checkbox"/> Spa Facials                                    | <input type="checkbox"/> Microneedling/DermaPen          |
| <input type="checkbox"/> Microdermabrasion                                   | <input type="checkbox"/> C02/Laser Resurfacing                          | <input type="checkbox"/> Thermage/Laser Tightening       |
| <input type="checkbox"/> Fraxel/Nonablative Laser                            | <input type="checkbox"/> Face Lift /Mini Lift/Neck Lift                 | <input type="checkbox"/> Blepharoplasty (Eyelid Surgery) |
| <input type="checkbox"/> Rhinoplasty (Nose Surgery)                          | <input type="checkbox"/> Other: _____                                   |  |

**Please list 3-6 main concerns you would like to address during your consultation today: (you may list fewer)**

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**How much downtime and/or time off work or social events can you devote to any medical skincare treatments?**

1-3 Days  4-6 Days  7-9 Days  9+ Days  No downtime preferred

**How much do you want to spend on your skin health and rejuvenation needs?**

\$0-\$500  \$501-\$1,000  \$1,001-\$2,500  \$2,501-\$5,000  \$5,001-\$7,500  \$7,501 +

**We accept CareCredit Healthcare card for your cosmetic procedures. Applying is fast, easy, secure and can be accessed from the office. Would you like to apply for CareCredit today?**

Yes  No

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date:**

Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.

**My ethnic origin is closest to:  
(Check one)**

- I. Very fair (Celtic and Scandinavian)
- II. Fair-skinned Caucasians with light hair and light eyes
- III. Pale-skinned Caucasians with dark hair and dark eyes
- IV. Olive-skinned (Mediterranean, some Asian, some Hispanic)
- V. Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)
- VI. Very dark-skinned (African)

**My eye color is:**

- Light blue 0
- Blue/green 1
- Green/gray/golden 2
- Hazel/light brown 3
- Brown 4

**My natural hair color at age 18 was:**

- Red 0
- Blonde 1
- Light brown 2
- Dark brown 3
- Black 4

**The color of my skin that is not normally exposed to sun is:**

- Pink to reddish 0
- Very pale 1
- Pale with a beige tint 2
- Light brown 3
- Medium to dark brown 4
- Dark brown – black 6

**If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:**

- Burn, blister and peel 0
- Burn, then when the burn resolves there is little or no color change 1
- Burn, but then turns to tan in a few days 2
- Get pink, but then turns to tan quickly 3
- Just tan 4
- Just gets darker 5
- My skin color is so dark I can't tell 6

**When was the last time the area to be treated was exposed to a significant amount of sunlight, a tanning bed, or tanning lotions?**

- Longer than one month ago 0
- Within the past month 1
- Within the past two weeks 3
- Within the past week 4

**Total Score**

**Circle All Nationalities Associated with your Genetic Makeup:**

Native American White Asian Hispanic Mediterranean Middle Eastern Afro-American Indian Irish English Greek German Italian Spanish/Portuguese

If your score is:	Your skin type is	Notes:
0 – 3	I	
4 – 7	II	
8 – 11	III	
12 – 15	IV	
16 – 19	V	
20 – 24	VI	

## Authorization to Leave Personal Health Information by Alternate Means

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

(Please check all that apply)

May leave detailed message on home voice mail # \_\_\_\_\_

May leave detailed message on work voice mail # \_\_\_\_\_

May leave detailed message on cell voicemail # \_\_\_\_\_

May leave detailed message with spouse/partner (name & phone#) \_\_\_\_\_

May leave message with other family member (name & phone#) \_\_\_\_\_

### ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that the doctor and hospital will use and disclose my personal health information to provide treatment, to receive treatment, to receive payment for care provided, and for other health care operations.

I have been informed of my medical providers Notice of Privacy Practices containing a more complete description of the uses and disclosure of my protected health information. I have been given the right to review and receive a copy of such Notice to Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date:



## SkinMD Cancellation Policy

In order to provide our patients with timely and effective service, we must require our patients to adhere to our cancellation policy.

Our cancellation policy is as follows:

- ❖ We require credit card information on file to hold & confirm appointments.
- ❖ We require 24- hour notice for any appointments needing cancellation or rescheduling.
- ❖ Patients who cancel or need to reschedule appointments without giving 24-hour notice; or patients who do not arrive at scheduled appointments (“no-shows”) will have a **\$150 charge billed to the credit card we have on file for them.**
- ❖ ***If possible***, we will accommodate late patients. If you will be 15 or more minutes late for an appointment, we require a phone call to determine whether we will be able to accommodate you or if you will need to reschedule. If we are unable to accommodate you, we will re-schedule you for the next available appointment and your credit card will be billed.

Thank you in advance for your consideration!

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**Patient Signature**

**Date:**

