

## VitaliaMed Patient Cosmetic Questionnaire

Name:		<input type="checkbox"/> F <input type="checkbox"/> M	D.O.B	
Address:				
City & State:			Zip Code:	
Day Phone:	Evening Phone:	Work Phone:	Email:	
Occupation:			How did you hear about us?	

### What are your skin care concerns?

<input type="checkbox"/> Enlarged pores	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Whiteheads
<input type="checkbox"/> Sun damage	<input type="checkbox"/> Sensitive skin	<input type="checkbox"/> Flushing
<input type="checkbox"/> Skin textures	<input type="checkbox"/> Pigmentation of the skin	<input type="checkbox"/> Capillaries
<input type="checkbox"/> Age spots or sun spots	<input type="checkbox"/> Acne	<input type="checkbox"/> Enlarged oil glands
<input type="checkbox"/> Fine lines/ Wrinkles	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Laxity of skin
<input type="checkbox"/> Oily skin	Other:	
How would you describe your skin? <input type="checkbox"/> Oily <input type="checkbox"/> Dry <input type="checkbox"/> Combination <input type="checkbox"/> Sensitive		

### HOW DO YOU CARE FOR YOUR SKIN? (PLEASE COMPLETE TABLE)

Product Type	Brand Name	Am	PM	Occas.	Never
Cleanser					
Toner					
Scrub/Exfoliate					
Masque					
Moisturizer					
Sun protection					
Eye cream					
Foundation					
Other					

Are you ALLERGIC to any oral or topical medications?  Yes  No

If YES, please explain:

Which procedure(s) are you interested in? (Circle all that apply)

Thermage	Botox	Fillers	Quantum IPL
Clear light acne treatment	Leg vein treatment	Chemical peels	Microdermabrasion

<b>Obagi</b>	<b>Photo rejuvenation treatment</b>	<b>General skin care treatments</b>	<b>Skin resurfacing</b>
<b>Other:</b>			

**What other treatments have you had? (Please indicate all that apply and give dates of last treatment)**

Glycolic peel:	Microdermabrasion:
Jessner's peel:	Accutane treatment:
Beta or salicylic acid peel:	Laser treatment:
TCA peel:	Skin cancer surgery:
Pheno peel:	Plastic surgery:
Dermabrasion:	Face lift:
Implants or prosthesis:	Botox or soft tissue filler:

**Are you ALLERGIC to any oral or topical medications?**     **Yes**     **No**

**If YES, please explain:**

**Which procedure(s) are you interested in? (Circle all that apply)**

<b>Thermage</b>	<b>Botox</b>	<b>Fillers</b>	<b>Quantum IPL</b>
<b>Clear light acne treatment</b>	<b>Leg vein treatment</b>	<b>Chemical peels</b>	<b>Microdermabrasion</b>
<b>Obagi</b>	<b>Photo rejuvenation treatment</b>	<b>General skin care treatments</b>	<b>Skin resurfacing</b>
<b>Other:</b>			

**Do you have history of:**

Abnormal bleeding or bruising:	Keloids or abnormal scarring:
Blood clots:	Herpes/fever blisters/cold sores:
Lupus/connective tissues disease:	Accutane Treatment in past year:
Weakened immune system:	Heart problems/pacemaker:
Poor healing:	Frequent infection:

**Medical & surgical history:**

**Medications:**

**For female patients:**

Are you or could you be pregnant?     **YES**     **NO**  
 Are you nursing?     **YES**     **NO**