SALMON CREEK PLASTIC SURGERY

FACIAL QUESTIONNAIRE

PATIENT NAME: _____ DATE:_____

HOW WERE YOU REFERRED TO US?_____

MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN OR A DEMATOLOGIST?

IF YES, FOR WHAT:_____

DO YOU SMOKE? YES_____ NO_____

DO YOU EXERCISE REGULARLY? YES_____ NO_____

DO YOU WEAR CONTACTS? YES_____ NO_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

_____CANCER

_____DIABETES

_____ARTHRITIS

_____THYROID IMBALANCE

_____HORMONE IMBALANCE

_____BLOOD CLOTTING ABNORMALITIES

_____SKIN DISEASE/ SKIN LESIONS

_____HIGH BLOOD PRESSURE

_____HIV/AIDS

_____HERPES

_____HEPATITIS

_____ANY ACTIVE INFECTIONS

_____FREQUENT COLD SORES

_____SEIZURE DISORDER

_____KELOID SCARRING

_____NECK INJURY

DO YOU HAVE ANY OTHER HEALTH PROBLEMS OR MEDICAL CONDITIONS?

IF YES, PLEASE LIST: _____

MEDICATIONS

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING: FOOD, ASPIRIN, LIDOCAINE, LATEX, ALOE VERA, HYDROCORTISONE, HYDROQUINONE OR SKIN BLEACHING AGENTS, LAVENDAR. (IF YES, PLEASE CIRCLE)

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SALMON CREEK PLASTIC SURGERY

FACIAL
QUESTIONNAIRE

SPA

DO YOU USE SPF SUNSCREEN ON YOUR FACE? YES_____ NO_____

HOW MUCH PLAIN WATER DO YOU CONSUME DAILY? _____

WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING? (PLEASE SPECIFY NAME OF PRODUCT) _____

YOUR SKIN EVALUATION

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE? (PLEASE CIRCE ONE)

I. ALWAYS BURNS, NEVER TANS

II. ALWAYS BURNS, SOMETIMES TANS

III. SOMETIMES BURNS, ALWAYS TANS

IV. RARELY BURNS, ALWAYS TANS

V. BROWN, MODERATELY PIGMENTED SKIN

VI. BLACK SKIN

DO YOU EVER EXPERIENCE SKIN BREAKOUTS OR OILY SHINE? YES_____ NO_____

DO YOU EVER EXPERIENCE THESE CONDITIONS ON YOUR FACE?

_____FLAKINESS _____TIGHTNESS _____OBVIOUS DRYNESS

DO YOU HAVE ANY SPECIAL FACIAL SKIN PROBLEMS? _____

CONSENT

I CERTIFY THAT THE PRECEDING STATEMENTS ARE TRUE AND CORRECT. I AM AWARE THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR'S, AESTHETICIAN, OR NURSE OF MY CURRENT MEDICAL AND HEALTH CONDITIONS. A CURRENT MEDICAL HISTORY IS ESSENTIAL FOR THE CAREGIVER TO EXECUTE THE APPROPRIATE TREATMENT PROCEDURES.

PATIENT SIGNATURE_____ DATE _____

AESTHETICIAN SIGNATURE_____ DATE _____

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