

North Valley Plastic Surgery - Skin Assessment

Patient's Name: _____ Age: _____ Date: ____/____/____

Are you currently under the care of a physician for your skin? **Y** **N**

If yes, why? _____

Have you ever seen a dermatologist or other physician for your skin? **Y** **N**

If yes, when and why? _____

Have you previously had any of the following:

Chemical Peel? **Y** **N** Type if Peel _____ Date _____

Laser Resurfacing, Dermabrasion, or MicroDermabrasion? **Y** **N**

Facial Surgery? **Y** **N** Procedure _____ Date _____

Have you done any aggressive exfoliation to your skin in the last 2 weeks? **Y** **N**

If yes, explain? _____

What **skin care products** do you use frequently? _____

Are you taking Accutane®? **Y** **N** If yes, what is the dosage and frequency? _____

Have you **ever** taken Accutane®? **Y** **N** If yes, when was it last taken? _____

What topical medications do you use or have you used? Retin-A® Hydroquinone

Please list any **nutritional** supplements you take: _____

Hypersensitivity and Skin Fragility

Have you ever had a skin allergy or sensitivity? (rash, irritation, peeling, swelling, hives, etc.) **Y** **N**

To: Cosmetics Fabrics Other: (i.e. Latex, etc.) _____

Do you have **any known allergies** to anything? **Y** **N**

If yes, please **list all allergies**: (this includes medications, aspirin, food, etc.) _____

Do you "flush" or "appear reddened" easily when you eat spicy foods, drink alcohol, get angry, go in the sun, etc.? **Y** **N**

Free Radical Exposure:

Do you smoke? **Y** **N** How much? _____

Do you consume alcohol? **Y** **N** How much? _____

Do you have a healthy diet? **Y** **N** List any dietary concerns: _____

Do you take vitamins? **Y** **N** Multi-Vitamins: _____

Antioxidants: _____

For Women Only:

Do you have regular periods? **Y** **N**

Are you going through menopause? **Y** **N**

Are you pregnant or lactating? **Y** **N**

Are you trying to become pregnant? **Y** **N**

During pregnancy did you ever experience hyper pigmentation or a "pregnancy mask"? **Y** **N**

Pigmentation (Fitzpatrick scale):

How do you tan?

Burn Usually Burn Sometimes Burn Rarely Burn Never Burn "Brown" Never Burn "Black"
Pigmentation: Even Uneven Birth mark Pregnancy Mask

Vascularity (telangiectasia or broken capillaries):

Nose area Cheek area Chin area Forehead Entire Face

Acne:

Do you have any history of acne or periodic breakout? Y N

Pimples White heads Black heads Enlarged Pores Acne Scars Cysts Flakiness

Do you only experience breakout during or around your menstrual cycle? Y N

Do you always have a pimple or some type of breakout? Y N

Facial Wrinkles:

Deep Wrinkles Crows Feet Fine Lines

Have you ever been treated with Botox: Y N Collagen: Y N

If yes, date of last treatment: _____

Skin Type:

Does your skin ever flake or feel tight and dry? Frequently Occasionally Very Rarely
Is your skin ever shiny a few hours after cleansing? Frequently Occasionally Very Rarely
How often do you experience blackheads or blemishes? Frequently Occasionally Very Rarely
How noticeable are your pores? Very T-Zone Not Very

Ability to Heal:

Does your skin appear fragile or burn easily? Y N If yes, explain _____
Do you have any problems healing from a cut or burn? Y N If yes, explain _____
Do you have any health problems? Y N If yes, explain _____
Do you ever use depilatories or waxes on your face? Y N If yes, explain _____
Have you ever had a "cold sore"? Y N If yes, when was you're your last cold sore _____

Sun History and Lifestyle:

Do you work inside? Y N Occupation _____
Are your hobbies done mostly outside? Y N Hobbies _____
In the past have you neglected to use a sunscreen when outdoors? Y N
Do you ever use tanning beds? Y N If yes, When? _____
Do you currently wear a sun protection product all day, everyday? Y N

Have you or any member of your family had skin cancer? Y N

If yes, Who? _____ Anatomical location of the lesion(s): _____

How do you want to improve your skin?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

What specific areas do you want to treat?

Neck Face Chest Back Other _____

Do you wear contact lenses? Y N

24 Hour Cancellation Policy

Due to last minute cancellations and rescheduling we will now have to enforce a 24-hour cancellation policy.

I understand that if I do not call 24 hours in advance to cancel or reschedule a Skin Care appointment, I will be charged a \$25.00 fee. If I break this policy 2 or more times in a row, I understand that I will be charged the full amount of the treatment scheduled. If I have a package, 1 treatment will be deducted.

We here at North Valley Plastic Surgery appreciate your understanding with this matter.
Once again thank you for your cooperation.

Patient Signature: _____ **Date:** _____

Skin Care Consent Form

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: Pregnancy (If so, do not do treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A®, Accutane®, or hormones.

I understand there may be some degree of discomfort, i.e., stinging, pinpricking sensation, hotness, or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may or may not actually peel, that each case is individual.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor/technician who performed the treatment.

I agree to refrain from tanning in tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment.

I understand that direct sun exposure is prohibited while I am undergoing treatment, and that the use of sun block protection with a minimum of SPF 15 is mandatory.

I have not had any other peel treatment of any kind within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.

I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-peel care instructions as I am directed.

Signature: _____ **Date:** _____

Signature of Technician: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

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