MONTROSE DERMATOLOGY + Cosmetics

1563 Ogden Road, Montrose CO 81401
voice 970-964-4036 fax 970-964-4038
www.montrosedermatology.com

Renata Raziano, MD PhD

Medical / Aesthetic Questionnaire for Cosmetic Procedures

Patient Name:_____

Email address: _____

Brilliant Distinctions Member ID: _____ (n/a if you are NOT a member)

What Advertisement / Referral brought you to our practice: _____

Questions About Skin (please check all that apply):

[ ] Normal
[ ] Dry
[ ] T-Zone/Combo
[ ] Thin
[ ] Saggy
[ ] Firm
[ ] Oily
[ ] Acne
[ ] Blackheads
[ ] Milia
[ ] Cystic
[ ] Acne-Scarred
[ ] Large Pores
[ ] Small pores
[ ] Rosacea
[ ] Eczema
[ ] Freckled
[ ] Sun-Damaged
[ ] Uneven/blotchy
[ ] Mature
[ ] Wrinkled
[ ] Patchy dryness
[ ] Broken surface capillaries
[ ] Other _____

Do you consider your skin [ ] Sensitive [ ] Resilient [ ]Unsure

Do you currently have any of the following: [ ] NONE

[ ] Open Wounds
[ ] Sunburn
[ ] Broken/ Infected skin
[ ] Cold Sores
[ ] Warts
[ ] Herpetic Breakout *

***If you are prone to herpetic breakouts you must start on a therapy 5 days before and continue for 5 days after your procedure**

Skin Type (when exposed to the sun for about 1 hour with no protection):

[ ] Always burns, never tans
[ ] Always burns, sometimes tans
[ ] Sometimes burns, always tans
[ ] Rarely, burns, always tans
[ ] Brown, moderately pigmented skin
[ ] Black skin

Personal / Lifestyle Questions (please check all that apply) [ ] NONE

[ ] Contact Lenses
[ ] Wax / Tweeze / Stringing
[ ] Depilatories
[ ] Wet Shave
[ ] Electric Shave
[ ] Permanent Makeup
[ ] Tanning Beds / Booths
[ ] Self Tanners / Spray Tans
[ ] Daily Caffeine Intake: _____
[ ] Daily Tobacco Use: _____

Patient Label

Are you currently under the care of a physician? [Yes] [No]. If yes, please explain:_____

_____

Are you currently taking ANY oral medication at this time? [YES] [NO]. If so, please list: _____

_____

Do you have (or have had) any of the following: [ ] NONE

[ ] Any active infection / Injury
[ ] Bleeding disorders / Bruising
[ ] Dark spots of pregnancy
[ ] Diabetes
[ ] Epilepsy or seizures
[ ] Hepatitis
[ ] Herpes simplex / Cold Sores
[ ] HIV / AIDs
[ ] Skin cancer
[ ] Neurological Disorders
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Amyotrophic Lateral Sclerosis (ALS)
[ ] Polycystic Ovarian Syndrome (PCOS)
[ ] Lupus
[ ] Myesthenia Gravis
[ ] Keloid Scarring / Formation
[ ] Other
_____

Do you have allergies / sensitivities to any of the following? (check all that apply) [ ] NONE

[ ] lidocaine
[ ] retinol
[ ] vitamin C
[ ] TCA
[ ] Phenol
[ ] salicylic acid
[ ] perfumes / fragrances
[ ] latex
[ ] hyaluronic acid
[ ] hydroquinone
[ ] ANY metal allergies
[ ] If any other allergies, please list:

_____

Have you ever used any other products that caused a bad reaction? If yes, please describe:

_____

_____

Do you take/use any of the following? [ ] NONE

[ ] Accutane
[ ] Anti-coagulants
[ ] Aspirin or Ibuprofen
[ ] Cortisone or steroids
[ ] Hormones/contraceptives
[ ] Hydroquinone / bleaching agent
[ ] Retin-A
[ ] Renova *
[ ] Differin *
[ ] Tazorac *
[ ] Avage *
[ ] EpiDuo *
[ ] Ziana *
[ ] Thyroid medication
[ ] St. John's Wort
[ ] Vitamin E
[ ] Other_____

*Increases sensitivity. Please discontinue use 2 weeks before and after treatment. Please consult with your physician before discontinuing any prescription.

Patient Label

FEMALE CLIENTS ONLY:

Are you pregnant or trying to become pregnant? [YES] [NO]

Are you lactating? [YES] [NO]

Are you using hormonal contraceptives? [YES] [NO] Specify:_____

Any menopause problems? [YES] [NO] Specify:_____

Are you undergoing any hormone replacement therapy? [YES] [NO] Specify:_____

ACHIEVING YOUR SKIN GOALS:

I am Interested in Discussing My: (please check all that apply)

[ ] Brown spots/age spots/freckles
[ ] Facial veins
[ ] Facial redness
[ ] Blotchy skin
[ ] Facial fine lines/wrinkles
[ ] Facial fullness/drooping
[ ] Drooping eyelids, brow
[ ] Fat Reduction
[ ] Scar revision
[ ] Mole removal
[ ] Acne
[ ] General aging issues
[ ] General brightness issues
[ ] General texture issues
[ ] Hair Removal Options
[ ] Other (please specify):_____

Previous Cosmetic Procedures:

Have you had ANY cosmetic procedure within the last six weeks? _____. If so, please explain: _____

_____

Have you EVER had any negative reaction to any cosmetic procedure? _____. If so, please explain: _____

_____

Have you EVER had any plastic surgery? _____. If so, please explain: _____

_____

Have you EVER had laser resurfacing? _____. When? _____. What type? _____

Do you have regular Botox® or dermal filler injections? _____. If so, please explain: _____

_____

I AM INTERESTED IN: (please check all that apply)

[ ] BOTOX® Cosmetic
[ ] Injectable Fillers
[ ] LATISSE® Length/fullness of eyelashes
[ ] Chemic Peel Facials
[ ] Treatment Facials
[ ] Skin care advice
[ ] Skin care products
[ ] Sunscreen advice
[ ] CoolSculpting
[ ] Acne treatment / Clogged & Congested Pores
[ ] Treatments for pigmentation (red or brown)
[ ] Hair removal
[ ] Collagen Induction Therapy
[ ] Other (please specify):_____

Patient Label

SKIN MATRIX EVALUATION

Please answer the following questions by circling the number which best describes you.

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	☐
	Fair-skinned Caucasian with light hair and light eyes	☐
	Pale-skinned Caucasian with dark hair and dark eyes	☐
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	☐
	Dark-skinned (Middle Eastern, Hispanic, Asians, some African)	☐
	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 tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
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 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 you tanned from natural light or used self tanners?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: _____

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

Additional skin response questions:

If you sustain an injury to your skin such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation?

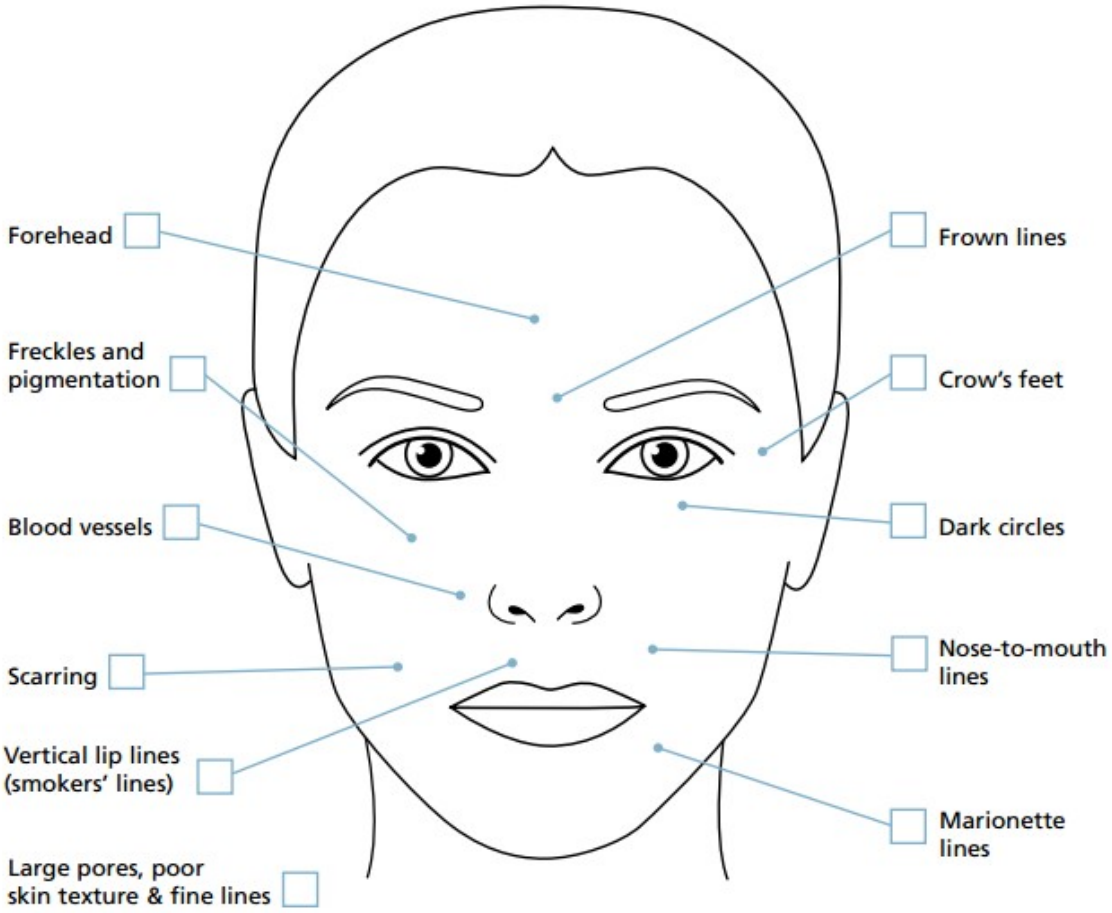
_____

What happens if you get an insect bite? _____

Patient Label

In the boxes provided, please rate these areas on a scale of 1 to 5

(1 being least bothersome, 5 being most bothersome).



If our office hosted an event to inform patients about cosmetic procedures, would you be interested in attending? [YES] [NO]

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Patients Signature:_____**Date:**_____

Consultants Signature:_____

Patient Label