READING DERMATOLOGY

MEDICAL, COSMETIC & SKIN CANCER CENTER

Client Consultation Form

About You

Todays Date:_____

Name:_____ Date of Birth:_____

Address:_____

_____

Home Phone:_____ Cell Phone:_____

E-Mail Address:_____

Employer:_____ Occupation:_____

Does your job require that you work outdoors? **No** **Yes**

How did you hear about us?_____

What would you like to achieve from your Treatment or Consultation today?

_____

_____

Allergies

Have you ever had an allergic reaction to any of the following? **(circle any that apply)**

If yes, please explain: _____

Cosmetics *Medications* *Food* *Animals* *Sunscreens* *Iodine*
Pollen *AHAs/BHAs* *Fragrances* *Shellfish* *Latex* *Ointments*
Other: _____

Medications

Please list all medications you are currently taking:_____

_____

_____

Skin Concerns

What areas of concern do you have regarding your skin? **(circle any that apply)**

Breakouts/Acne	*Blackheads/Whiteheads*	*Excessive Oil*	*Rosacea*
Broken Capillaries	*Redness*	*Dehydrated*	*Dry Skin*
Uneven Skin Tone	*Sun Damage*	*Wrinkles/Fine Lines*	
Flaky Skin	*Sun Spot/Liver Spot/Brown Spot*	**Other:** _____	

Eyes: *Dehydrated* *Wrinkles* *Puffiness* *Dark Circles* Other: _____
Lips: *Dehydrated* *Cracked/Chapped* Other: _____

About Your Skin

Have you ever had a facial before? **No** **Yes, When?** _____
Have you ever had **Chemical Peels, Laser or Microdermabrasion?** **No** **Yes**
In the last month? **No** **Yes, When? _____**
Do you use or have you ever used: **Accutane, Retina-A, Renova, Adapalene Hydroxyl Acid, or Retinol/Vitamin A** derivative products?
No **Yes**, when and how often? _____
Do you use Glycolic Acid or Salicylic Acid? **No** **Yes**
What SPF do you use on your face? _____ How often? _____
What SPF do you use on your body? _____ How often? _____
Have you recently used a tanning bed or had sun exposure change the color of your skin?
No **Yes**, Specify _____
Have you experienced Botox, Restylane or Collagen injections? **No** **Yes**
Specify _____
Were you satisfied with the results? **No** **Yes**
If no, why not? _____
Do you plan on exercising in the next 24/48 hours? **No** **Yes**

About Your Skin Care Products

What type of skin care products are you currently using? (list brand where known)

Soap_____	Toner_____
Mask_____	Eye Product_____
Cleanser_____	Day Moisturizer_____
Exfoliator_____	Scrubs_____
Sunscreen _____	Body Lotions_____
Night Moisturizer _____	Other_____

Makeup Products _____

Have you used any hair removal methods in the past six months? **No** **Yes, when?**
(Circle any that apply) Shaving Waxing Electrolysis Tweezing Threading Depilatories Laser IPL

Male Clients Only

What is your current shaving system? Please circle: **Wet Shave Dry Shave Electric Shave**
Do you experience irritation with shaving? **No Yes** Ingrown Hairs? **No Yes**

Female Clients Only

Are you taking oral contraceptives? **No Yes**
Specify: _____
Are you pregnant or trying to become pregnant? **No Yes**
Are you lactating? **No Yes**
Any menopause problems? **No Yes**
Specify: _____
Are you undergoing any hormone replacement therapy? **No Yes**
Specify: _____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that is supersedes and previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release Reading Dermatology and/or skin care professional from liability and assume all responsibility thereof. All services provided by this medical practice are provided either by one of our duly licensed medical professionals or by a trained assistant under the supervision and at the direction of one of our duly licensed medical professionals. No services provided by this medical practice are provided by an individual holding less than a registered nurse license unless such individual is being directed and overseen by another individual holding no less than a registered nurse license.

Client Signature_____
Date:_____