



READING DERMATOLOGY

MEDICAL, COSMETIC & SKIN CANCER CENTER

Client Consultation Form

About You

Today's 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 it supersedes any 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: _____