



John Q. Cook, M.D.
Aesthetic Plastic Surgeon

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SKIN CARE PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

PATIENT INFORMATION

MR/MRS/MS _____ PREFERRED FIRST NAME _____ TITLE _____ (_____) _____
HOME PHONE

FIRST NAME _____ M.I. _____ LAST NAME _____ (_____) _____
WORK PHONE

ADDRESS _____ APT. _____ (_____) _____
MOBILE PHONE

CITY _____ STATE _____ ZIP _____ (_____) _____
PAGER

_____ SINGLE MARRIED OTHER (_____) _____
SOCIAL SECURITY NUMBER OTHER

_____ MALE FEMALE (_____) _____
BIRTH DATE AGE FAX

I would like Dr. Cook to keep me informed about Advances in Plastic Surgery via email. _____
E-MAIL ADDRESS

REFERRAL INFORMATION

REFERRED BY PATIENT REFERRED BY PHYSICIAN REFERRED BY PATIENT REFERRED BY PHYSICIAN

REFERRAL SOURCE 1 NAME _____ REFERRAL SOURCE 2 NAME _____

ADDRESS (IF AVAILABLE) _____ ADDRESS (IF AVAILABLE) _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN NAME _____

EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP _____

(_____) _____
HOME PHONE

(_____) _____
WORK PHONE

SPOUSE

FIRST NAME _____ LAST NAME _____

SPOUSE'S EMPLOYER _____

(_____) _____
SPOUSE'S PHONE



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CONSULTATION AND SKIN EVALUATION FORM

This form is to correctly evaluate your special needs. This information is confidential, and will not be passed to a third party.

Patient Name: _____

Who recommended me to you? _____ May I send a thank-you
Letter to them? Yes No

YOUR HEALTH

1. Within the last year have you been under a physician's care? Yes No
2. Within the last year have you been under a dermatologist's care? Yes No
3. Within the last 9 Months, have you undergone any surgery? Yes No

If yes, please specify _____

4. Have you had any of these health problems in the past or present? cancer diabetes
 epilepsy heart problem hormone imbalance spinal injury hysterectomy
 thyroid condition systemic disease other _____

5. List any medications, supplements, vitamins, diuretics, slimming tablets etc.
that you take regularly _____

6. Do you smoke? Yes No
7. Do you exercise regularly? Yes No
8. Do you follow a restricted diet? Yes No
9. Do you have regular sleep habits? Yes No
10. Do you wear contacts? Yes No
11. Do you have metal implants or a pacemaker? Yes No

EXFOLIATION HISTORY

12. Have you had chemical peels, laser, IPL, microdermabrasion or dermabrasion? Yes No
in the last month? Yes No
13. Do you use Retin-A, Renova, or Adapalene/Differin? Yes No
in the last 3 months? Yes No
14. Do you use an acne medication? Yes No • in the last 6 months? Yes No

15. Are you currently using any products containing the following ingredients? glycolic acid any hydroxy
acid product any exfoliating scrubs Vitamin C Vitamin A derivatives (i.e. retinal) Copper

YOUR SKIN

16. With what temperature of water do you cleanse? Cool Warm Hot
17. Do you have any special skin problems pertaining to your face or body? Yes No
18. What skin care products are you currently using? Soap Cleanser Toner Moisturizer
 Masque Exfoliator Eye Products Other _____

CAPILLARY ACTIVITY

19. Do you burn easily in moderate sunlight? Yes No
20. Do you blush easily when nervous? Yes No
21. Do you have a tendency to redness? Yes No
22. Do you suffer from sinus problems? Yes No

OIL SECRETION

23. Do you ever experience oily shine during the day? Yes No Occasionally
24. Do you ever experience skin breakouts? Yes No Occasionally

MOISTURE HYDRATION

25. How much plain water do you consume daily? _____
26. How many alcoholic beverages do you consume weekly? Yes No
27. Do you ever experience these conditions on your skin? Flakiness Tightness
 Obvious Dryness • If yes how many per week? _____
28. What SPF sunscreen do you use on your face? Yes No
29. Do you sunbathe and/or use tanning beds? Yes No Past

NERVE ACTIVITY

30. Do you drink caffeinated beverages (coffee, tea, soft drinks)? Yes No
How much daily? _____
31. Do you ever experience a burning, itching sensation on your skin? Yes No
32. What is your pain threshold? Low Medium High
33. Have you ever experienced claustrophobia? Yes No
34. Have you ever had a reaction to any of the following? Cosmetics Medication Iodine
 Pollen Food Hydroxy Acids Animals Fragrance Sunscreens other _____

FEMALE PATIENTS ONLY

35. Are you taking oral contraception? Yes No
36. Are you pregnant or trying to become pregnant? Yes No
37. Are you lactating? Yes No
38. Have you experienced menopause? Yes No

MALE PATIENTS ONLY

39. What is your current shaving system? Electric Wet Shave
40. Do you experience irritation from shaving? Yes No
41. Do you experience ingrown hairs? Yes No

YOUR GOALS

42. What three things would you like to change and/or improve about your appearance?
1. _____
2. _____
3. _____
43. How important are these goals to you? _____
44. How much time are you willing to spend to achieve your goals? _____
45. When would you like to see your goals met? _____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Patient Signature

Date

Print Name

Date of Birth