pure.dermatology

where.skin.matters

PATIENT AESTHETIC GLOBAL CONSULTATION QUESTIONNAIRE

PATIENT NAME : _____ **DATE :** _____

Cosmetic Consultations are personal. Our providers seek to understand your specific goals and concerns. While we stress the health of the skin above all else, we will focus on creating a cosmetic treatment plan that is tailored just for you and your budget.

Please describe, in detail, what cosmetic concerns you have. Please be as specific as possible. Examples of descriptions are the following: brown spots on my skin, redness on my cheeks, lines on my forehead, wrinkles around my eyes or upper lip, etc.

_____

What is your ethnicity? _____
Please be as specific as possible including distant relatives. This helps us determine how much melanin is in your skin visible or not. This reduces complications associated with certain procedures.

Have you had a complete skin exam within the last year? Yes: _____ **No:** _____

If yes, who performed your exam? _____

May we obtain a copy of your medical notes from your last exam?
Yes _____ (We will provide a HIPAA release for you.)
No _____ (This may impact your treatment plan.) If no, we are happy to schedule an exam at Pure Dermatology.

Do you have a history of skin cancer? Yes: _____No: _____

Please list location and type if known: _____

Do you have a history of autoimmune diseases or neurological disorders such as Epilepsy (seizures), lupus, rheumatoid arthritis, myasthenia gravis, Graves' Disease, multiple sclerosis, AIDS/HIV etc.?
Yes: _____ No: _____ If yes, please list: _____

If yes, how are you treating your condition? _____

Do you smoke or have a history of smoking? Yes: _____ No: _____ If yes, how long? _____
If I do, I understand this may impact my ability to heal. _____ Please Initial

I acknowledge I will alert my skin care specialist if I wear contacts, so the contacts are removed prior to certain treatments.
Do you wear contact lenses? Yes: _____ No: _____

Have you been on Accutane (isotretinoin) during the past 12 months? Yes: _____ No: _____
If yes, when did you stop? _____
*Active use of this drug may dramatically alter the skin's ability to heal.

Are you pregnant or lactating? Yes: _____ No: _____

Are you planning on becoming pregnant soon? Yes: _____ No: _____

Teresa Mann, MD, PC Board Certified: American Board of Dermatology
t: 406.586.7873 | f: 406.586.2332
2233 West Kagy Blvd. Suite 2 | Bozeman, Montana 59718
www.puredermbozeman.com

Do you have a history of keloid scarring, skin darkening around an injury or other skin sensitivities?
Yes: _____ No: _____
If yes, please describe. _____

Do you have a history of bleeding or clotting disorders? Yes: _____ No: _____
If yes, what condition? _____

Have you ever had DVT? Yes: _No: _____ If yes, when? _____

Are you currently taking Tamoxifen? Yes: _____ No: _____

Are you prone to cold sores (Herpes Simplex Virus)? Yes: _____ No: _____
I acknowledge that I may need a prescription from my medical provider prior to having any treatments done. I am aware treatments could trigger cold sores. _____ Please Initial

You may need to contact your primary care provider for a refill on your medication. Please advise us when you last took your medication. Date: _____

Have you been diagnosed with rosacea or acne? Yes: _____ No: _____
If yes, what medications have you used or are you currently using? _____

Do you have any known allergy to metal of any kind? Yes: _____ No: _____
If yes, please describe what metal and the reaction: _____

Do you have any known allergy to Benzocaine, Tetracaine, Epinephrine, or Lidocaine? (Have you ever reacted to numbing during a dental procedure or other numbing injections?) Yes: _____ No: _____
Please describe: _____

Do you have any known drug allergies or other known allergies? Yes: _____ No: _____
If yes, please list any known allergies: _____

I acknowledge and am aware that there is a possibility of an allergic reaction to anything applied to the skin. I acknowledge I may request a patch test of any product. _____ Please Initial.
*Note our numbing cream contains Benzocaine, Tetracaine, and Lidocaine.

Date of last exposure to the sun, tanning booth, self-tanner, or spray tan. _____

What does your skin do in 1 hour in the sun without protection? _____

Do you have any tropical or high-altitude vacations or activities planned? This includes skiing.
Yes: _____ No: _____ When: _____

Have you had any recent cosmetic or exfoliating procedures, including Botox, Xeomin, filler, facial plastic surgery, facial surgery, facial implants of any kind, etc.? Yes: _____ No: _____
If yes, please describe in detail the location of the procedure/implant.
_____

Have you had any complications such as excessive bruising, nodules, or biofilm?
Yes: _____ No: _____
If yes, please describe in detail: _____

Do you have any chronic inflammation or current infections? Yes: _____ No: _____
Please describe: _____

Teresa Mann, MD, PC Board Certified: American Board of Dermatology
t: 406.586.7873 | f: 406.586.2332
2233 West Kagy Blvd. Suite 2 | Bozeman, Montana 59718
www.puredermbozeman.com

Have you had any major dental work in that last month including root canals or crowns? Yes: _____ No: _____

Do you have any important social events or pictures planned soon? Yes: _____ No: _____
If yes, when? _____

Do you wear a sun protection product daily? Yes: _____ No: _____

If yes, what specific product do you use? _____
How much do you apply? _____ How often and how much do you apply? _____

I acknowledge that I will avoid direct sun exposure and will apply a sunscreen MULTIPLE TIMES daily when participating in BBL, HALO PRO, DCA, Chem Peel, Microneedling and Laser Hair Reduction procedures.
_____ Please Initial

I acknowledge that ANY Halo/BBL/Laser/ Microneedling /LN2/DCA procedure may lighten or darken the skin.
_____ Please Initial

I acknowledge that certain types of pigmentation such as melasma, seborrheic keratosis or actinic keratosis may not respond to the above treatments.
_____ Please Initial

I acknowledge that if I have used Hydroquinone, Retin A, Atralin, Differin, tretinoin, retinols, BPO acne products, glycolic acid, salicylic acid, and/or lactic acid in the past two weeks, I will notify my skin care specialist.
Please list all products that you are currently using, including self-tanning products: _____

*I acknowledge that I will tell my skin care specialist of any medications/supplements that I am taking. (Some medications and supplements can alter the skin's ability to heal, cause you to bleed or bruise, and may promote pigmentation changes in the skin). Please list such medications as Advil, ibuprofen, Aleve, aspirin, Motrin, Naprosyn, Birth Control, IUDs, antibiotics, antidepressants, blood pressure medications, vitamins, garlic, turmeric, fish oil, etc.
Please list: _____

*I acknowledge my obligations to follow the aftercare instructions and visit my skin care specialist as needed.
_____ Please Initial

*ADDITIONAL SKIN HISTORY: Please list anything else you think we should know about your skin and / or general health on the line below.

_____

Patient Signature: _____ **Date:** _____

Pure Dermatology Staff Member Signature: _____ **Date:** _____

Teresa Mann, MD, PC Board Certified: American Board of Dermatology
t: 406.586.7873 | f: 406.586.2332
2233 West Kagy Blvd. Suite 2 | Bozeman, Montana 59718
www.puredermbozeman.com