**Profile Sheet**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Type: Fair \_\_\_\_\_\_\_\_ Medium \_\_\_\_\_\_\_\_\_\_ Tan \_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any questions regarding this procedure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** (medications, creams, adhesive tape, ointments, milk, apples, citrus, grapes, aloe vera, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What reactions have you experience from an allergy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications and skin care products you are taking and for what reason?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced any reactions with anesthesia? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received radiation treatment: \_\_\_\_\_\_\_\_\_ Please Explain \_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_ How long? \_\_\_\_Do you drink? \_\_\_\_ # of drinks per week? \_\_\_\_

Drug Use \_\_\_\_

Have you ever been Yes No Yes No

treated for:

High blood pressure \_\_\_ \_\_\_ Liver Disease \_\_\_ \_\_\_

Heart problems or stroke \_\_\_ \_\_\_ Cancer \_\_\_ \_\_\_

Angina \_\_\_ \_\_\_ Varicose Veins \_\_\_ \_\_\_

Shortness of breath \_\_\_ \_\_\_ Anemia \_\_\_ \_\_\_

Pulmonary Embolism \_\_\_ \_\_\_ Astnma/ Bronchitis \_\_\_ \_\_\_

Migraine Headaches \_\_\_ \_\_\_ Fever Blisters \_\_\_ \_\_\_

Hemophilia \_\_\_ \_\_\_ Blood Transfusion \_\_\_ \_\_\_

Stomach Problems \_\_\_ \_\_\_ Yellow Jaundice \_\_\_ \_\_\_

Arthritis \_\_\_ \_\_\_ Hepatitis \_\_\_ \_\_\_

Bell’s Palsy \_\_\_ \_\_\_ Facial Nerve Damage \_\_\_ \_\_\_

Epilepsy \_\_\_ \_\_\_ Glaucoma \_\_\_ \_\_\_

HIV \_\_\_ \_\_\_ Glasses/ Contacts \_\_\_ \_\_\_

Diabetes \_\_\_ \_\_\_ Mitral Valve Prolapse \_\_\_ \_\_\_

Depression \_\_\_ \_\_\_ Mental Conditions \_\_\_ \_\_\_

Have you ever taken Accutane? \_\_\_\_\_\_ When? \_\_\_\_\_\_ Dosage? \_\_\_\_ Months?\_\_\_\_\_

Have you used Tretinoin? \_\_\_\_\_\_\_ %\_\_\_\_\_\_\_ Do you have Herpes simplex? \_\_\_\_

Valacyclovir € Zovirax € Valtrex €

Birth control pills? \_\_\_\_ Currently Pregnant? \_\_\_\_ Breast Feeding?\_\_\_\_

Attmepting Pregnancy? \_\_\_

Skin Tans? € Skin Burns? € Pre cancerous lesions? \_\_\_\_\_ Lesion Removal? \_\_\_\_ When?\_\_\_\_ Mole Removal?\_\_\_\_ When? \_\_\_\_ Hair Removal? \_\_\_\_ Wax? € Electrolysis? € Laser? € Permanent make-up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Resurfacing Procedures (Please Give Dates)**

CO2\_\_\_\_\_ Erbium\_\_\_\_\_\_ Dermabrasion\_\_\_\_\_ Peels: Phenol\_\_\_\_ TCA\_\_\_\_ Glycolic\_\_\_\_\_ Salicylic\_\_\_\_\_ Other Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Skin Care Products**

Cleanser\_\_\_\_\_\_\_\_\_\_\_\_\_ Times/Day\_\_\_\_\_\_\_\_\_\_\_\_\_ Toner/Astringent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Moisturizer\_\_\_\_\_\_\_\_\_\_\_ Eye Cream\_\_\_\_\_\_\_\_\_\_\_\_\_ Exfoliator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunscreen Use\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_ Make-up\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Areas Of Concern**

Lines/Wrinkles € Skin Texture € Skin Elasticity € Even Color Tone € Psoriasis/Exzema € Acne Scars € Acne (pimples,whiteheads,blackheads) €

Skin Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Concerns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Skin Analysis**

Oily € X-Dry € Dry € Normal € Combination € Thick € Thin € Normal € Other €

Wrinkles\_\_\_\_ Fine\_\_\_\_ Deep\_\_\_\_\_ Acne\_\_\_\_\_ Type\_\_\_\_\_ Acne Scars\_\_\_\_\_

Other Scarring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Keloids\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scarring\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pigmentation\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telangiectasias\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mlia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comedones\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enlarged Pores\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Elastosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Keratosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Color Analysis**

Caucasian light€ medium€ dark€ very dark€ Indian light€ medium€ dark€ very dark€

Asian light€ medium€ dark€ very dark€ African American light€ medium€ dark€ verydark€

Hispanic light€ medium€ dark€ very dark€ Ethnic Combination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_