Name:_____ DOB:_____ Age:_____

At *ADC/AE* your well-being and long term satisfaction are of utmost importance to us. Through our extensive experience, well-chosen interventions and procedures result in the greatest improvement and satisfaction for you.

Please be accurate and exact in providing all of your medical history, medications, etc. as well as your previous skin treatments, procedures, surgeries, and your neural-dermal status. It is very important to have accurate and complete information in order to thoroughly understand your needs, and to best plan the most effective cosmetic dermatology treatments for your unique skin.

In order to receive AE treatments, you must answer all of the following questions completely and fully. The following questions will help us tailor the best treatment plan to meet your specific needs.

Medical History: Your general Health: Poor Fair Good Excellent
Do you take birth control pills? No Yes Past Do you drink alcohol? No Yes Amount per week: _____ Year Quit: _____
Do you smoke? No Yes Past # packs/day_____ Age began _____ Age Quit _____
Do you use any recreational or IV drugs? No Yes If yes, describe:_____
Retinoid use: No Yes Finacea, Tretinoin, Refissa, Renova, Differin, Retin A, Tazorac
H/O Herpes/Cold Sores: No Yes Treated with: _____
H/O of Isotretinoin: No Yes Last used_____ Are you pregnant or nursing? No Yes Do you intentionally tan? No Yes

Cosmetic Goal: 1. Circle all that apply to your cosmetic concerns: Acne Skin Discoloration Red/brown marks Skin Tone Scars
Leg (Spider) Veins Sun Damaged / Aging /Sagging Skin Unwanted Hair Port Wine Stains Seborrheic Keratoses
Tattoo Removal Torn /Elongated Ear Lobe Cellulite /Localized Area of Fat Wrinkles
2. What one or two main concerns would you like to discuss today? _____
3. Knowing 100% resolution of cosmetic concerns is not possible, would you be satisfied with 30-40% improvement? Yes No
4. Rank (by number of a scale of 1-5: (Only use each number once. 1 as most important, 2 as less, and so on) the following selection factors:
Cost_____ Recovery Time_____ Number of Treatments needed_____ Discomfort_____ Injections_____

Cosmetic History 5. Have you had any previous cosmetic procedures? No Yes
5a. If yes, list your previous procedures _____
5b. Were satisfied with the results of all your previous cosmetic procedures/surgeries? Yes No Comments _____

Dermal/Neural Impact Since one's stress level and skin habits greatly affect one's response to treatment, please answer the following questions completely and accurately.
6. Have you had a major life stress within the last 6 months / or coming soon? No Yes Circle: death of a loved one divorce job moved
major illness up-coming major event Other: _____
7. How will having a cosmetic procedure help any of your problems? _____
8. Are you considered a nervous person, anxious, or been treated for nerves? Yes No
9. Are you worried about the way you look? Yes No
10. Do you wish you could think about the way you look less often? Yes No
11. How many times do you examine yourself in the mirror each day? _____
12. How many minutes of hours in an average day do you think about the way you look? _____ minutes or hours
13. Have your cosmetic concerns gotten in the way of doing things with your friends / family? Yes No
14. Do you pick at, cut or otherwise harm your skin? Yes No
Additional history: _____
_____
Comments: _____
_____
Pt. contact phone: _____ I give permission to leave detailed messages regarding my AE care on this number: Yes No
Patient E-Mail Address: _____ I wish to receive e-mailed AE marketing information and specials: Yes No