

# Skin Matters

A Division of Patrick H. Pownell, M.D., PA

## Patient Consultation

1. Have you ever seen a dermatologist for your skin? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain \_\_\_\_\_

2. Are you presently under a doctor's care? \_\_\_\_\_ Why? \_\_\_\_\_

3. Are you currently taking or have you ever used: Tranquilizers \_\_\_\_\_  
Antibiotics \_\_\_\_\_ Diuretics \_\_\_\_\_ Birth control or hormones \_\_\_\_\_  
Antidepressants \_\_\_\_\_ Steroids \_\_\_\_\_ Allergy Medications \_\_\_\_\_  
Coumadin \_\_\_\_\_ Aspirin \_\_\_\_\_  
List all oral medications you are taking, including OTC drugs: \_\_\_\_\_  
\_\_\_\_\_

4. List any topical medications (prescription or over the counter) you use or have used:  
Acne \_\_\_\_\_ Retin-A/Renova \_\_\_\_\_ Glycolic acid \_\_\_\_\_ Tazorac \_\_\_\_\_  
Differin \_\_\_\_\_ Other \_\_\_\_\_

5. Do you take vitamins or food supplements? \_\_\_\_\_ List \_\_\_\_\_

6. Have you ever taken Accutane? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

7. List all medications you are allergic to: \_\_\_\_\_

8. Have you ever had a skin allergy? \_\_\_\_\_ Cosmetics \_\_\_\_\_ Fabrics \_\_\_\_\_  
Aspirin \_\_\_\_\_ Rashes \_\_\_\_\_ Other \_\_\_\_\_ Explain \_\_\_\_\_

9. Do you have a history of Chronic Acne \_\_\_\_\_ Chronic Skin Sensitivity \_\_\_\_\_  
Explain \_\_\_\_\_

10. Have you ever had an adverse reaction after using a skin care regimen? \_\_\_\_\_  
If yes, describe (rash, irritation, peeling, sensitivity, etc.) \_\_\_\_\_  
\_\_\_\_\_

11. **For ladies only:** Are you pregnant or lactating? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you have regular periods? \_\_\_\_\_ Are you going through menopause? \_\_\_\_\_  
During pregnancy, did you get hyperpigmentation or masking? \_\_\_\_\_

12. Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

13. Do you consume alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

14. Do you have a history of acne or periodic breakout? \_\_\_\_\_  
Pimples \_\_\_\_\_ Cysts \_\_\_\_\_ Whiteheads \_\_\_\_\_ Blackheads \_\_\_\_\_  
Enlarged pores \_\_\_\_\_ Acne scars \_\_\_\_\_ Hormone related \_\_\_\_\_  
Frequency \_\_\_\_\_

15. Is your skin: Dry \_\_\_\_\_ Combination \_\_\_\_\_ Oily \_\_\_\_\_ Acne Prone \_\_\_\_\_

16. Does your skin appear fragile or burn easily? Yes \_\_\_\_\_ No \_\_\_\_\_

17. Do you form a thick or raised scar from a cut or burn? Yes \_\_\_\_\_ No \_\_\_\_\_

18. Do you wax or use depilatories on your face? Yes \_\_\_\_\_ No \_\_\_\_\_ Frequency \_\_\_\_\_

19. Do you have a history of cold sores? Yes \_\_\_\_\_ No \_\_\_\_\_ Frequency \_\_\_\_\_  
Have you had any active lesions in the last 4-6 weeks? \_\_\_\_\_

20. Have you ever had chemotherapy or radiation? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please explain \_\_\_\_\_

21. I certify that I am not HIV positive, have AIDS or Hepatitis C. (Initial, please) \_\_\_\_\_

22. Have you had facial surgery, facial peels, laser surgery, microdermabrasion, recent Botox or Restylane? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_

23. Have you or any member of your family had skin cancer? Yes \_\_\_\_\_ No \_\_\_\_\_  
Anatomical location \_\_\_\_\_

24. Are you active outdoors? \_\_\_\_\_ Explain \_\_\_\_\_  
In the past, have you neglected to use sunscreen when outdoors? Yes \_\_\_\_\_ No \_\_\_\_\_

25. Do you use **daily** sun protection? Yes \_\_\_\_\_ No \_\_\_\_\_ SPF \_\_\_\_\_

26. Do you or have you ever-used tanning beds? Yes \_\_\_\_\_ No \_\_\_\_\_ Frequency \_\_\_\_\_

27. What is your ethnic background? \_\_\_\_\_

28. Describe your daily skincare routine: A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

29. Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

I hope to achieve the following results (check all that apply): Diminish fine lines \_\_\_\_\_  
Control acne \_\_\_\_\_ Smooth skin texture \_\_\_\_\_ Shrink enlarged pores \_\_\_\_\_  
Even pigmentation \_\_\_\_\_ Reduce scarring \_\_\_\_\_ Other \_\_\_\_\_

The areas I would like most to improve are: Around the eyes \_\_\_\_\_ Cheeks \_\_\_\_\_  
Neck \_\_\_\_\_ Around the mouth \_\_\_\_\_ Forehead \_\_\_\_\_ Hands \_\_\_\_\_ Chin \_\_\_\_\_  
Browline \_\_\_\_\_ Chest \_\_\_\_\_ Arms \_\_\_\_\_ Other \_\_\_\_\_

***I hereby consent to allow the staff at Skin Matters to perform services as deemed necessary for cosmetic improvement, including, but not limited to, microdermabrasion, chemical exfoliation and topical cosmetic therapy.***

Signature \_\_\_\_\_ Date \_\_\_\_\_