# Greenville Plastic Surgery, P.A.

## CLIENT INFORMATION AND CONSENT FORM: SKIN CARE

Name _____ Date of Consultation _____

Address _____

City _____ State _____ Zip _____

Home phone (____) _____ Cellular phone (____) _____

E-mail _____ Date of birth _____

Emergency contact and telephone number _____

How did you find out about us? Name of person / website / other: _____

What is your goal for today's visit and/or future visits? _____

Are you using any blood/skin thinning products and/or drugs? Yes / No

Are you exposed to the sun daily or are you considering spending more time in the sun soon? Yes / No

Do you use a tanning bed? Yes / No If yes, how often and last time: _____

Have you been under care of a dermatologist or other medical professional in the last year? Yes / No If yes, please explain: _____

Please list any other illness or condition you are currently being treated for by a medical professional: _____

_____

Have you had any recent surgery, including plastic surgery? Yes / No If yes, explain: _____

_____

Have you ever been treated for cancer? Yes / No If yes, when and what types of therapies were used? _____

_____

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Have you had any piercings, tattoos, or permanent makeup? Yes / No If yes, where on your person?

_____

Do you smoke? Yes / No

Do you follow a restricted diet? Yes / No If yes, please specify: _____

_____

Do you follow a regular exercise program? Yes / No

What is your stress level? ____High ____Medium ____Low

Have you used an acne medication? Yes / No If yes, when? _____ Which drug? _____

List any other medications you are presently taking: _____

List any over-the-counter medications (including vitamins, herbal supplements, aspirin, etc.) that you take regularly: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

Do you form thick or raised scars from cuts or burns? Yes / No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes / No If yes, describe: _____

Do you experience any problems sleeping? Yes / No How many hours do you sleep each night? _____

Do you wear contact lenses? Yes / No Do you have any metal implants or wear a pacemaker? Yes / No

Do you suffer from: Claustrophobia? Yes / No Sinus problems? Yes / No

Are you taking oral contraceptives? Yes / No If yes, please specify: _____

Any recent changes to or from your contraceptive treatment? Yes / No If yes, what and when? _____

_____

Are you pregnant or trying to become pregnant? Yes / No Are you lactating? Yes / No

Do you have any problems relating to menopause? Yes / No If yes, please explain: _____

_____

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Have you ever had an allergic reaction to any of the following? *(Please check all that apply and explain)*

☐ Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine ☐Pollen
☐ AHAs ☐ Fragrance ☐ Shellfish ☐ Latex ☐ Drugs ☐ Other: _____

If yes, please explain: _____

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past week? Yes / No

Are you using/have you used Retin-a, Renova, Accutane, Adapalene, Differin, Retinol, or Vitamin A derivative products ? Yes / No

Have you ever had any adverse reactions to a skin care treatment or product? Yes / No

If yes, please explain: _____

Have you ever had an adverse reaction after using any skin care product?

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun sensitivity ☐ Breakout

If yes, please explain: _____

Have you had any of these health conditions in the past or present?
*(Please check all that apply and provide additional information in the space provided)*

_ Cancer
_ Hormone imbalance
_ Systemic disease
_ High blood pressure
_ Spinal injury
_ Thyroid condition
_ Hysterectomy
_ Diabetes
_ Heart problem
_ Varicose veins
_ Arthritis
_ Eczema/Psoriasis
_ Epilepsy
_ Seizure disorder
_ Fever blisters
_ Hepatitis
_ Herpes
_ Frequent cold sores
_ Immune disorders
_ HIV/AIDS
_ Lupus
_ Metal bone pins or plates
_ Phlebitis, blood clots, poor circulation
_ Blood clotting
_ Asthma
_ Psychological treatment
_ Skin diseases/skin lesions
_ Insomnia
_ Keloid scarring
_ Skin disease/skin lesions
_ Headaches (chronic)
_ Any active infection

Additional information: _____

_____

Please read the other side of this form. If you have any questions, please consult us before signing.

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# Cancellation/Late Policy

As a courtesy, we will send an email and/or text reminder approximately 48 hours prior to your scheduled appointment. Please respond accordingly to those reminders as it confirms your upcoming appointment. We understand that sometimes schedule adjustments are necessary therefore we request that you reschedule or cancel your appointment with at least a 24 hour notice. This allows for more efficient scheduling. In the event you need to reschedule or cancel your service, please call 252-758-6627. Missed appointments without prior notification may result in a $50.00 cancellation fee.

Also note, if you are more than 10 minutes late for your scheduled appointment there is a possibility you may not be seen and will have to reschedule.

By signing this form, I have read and understand the above.

_____

Patient Signature Date

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**Please note that skin care treatments can have certain side effects, such as redness, rash, swelling, tenderness, etc.**

I have read the above information and if I have any concerns, I will address these with my esthetician. I give permission to my esthetician to perform the skin care procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negatives reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home products/ post-treatment care, I will consult the esthetician immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____ Date _____

Esthetician _____ Date _____

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