WATER'S EDGE DERMATOLOGY
PATIENT PROFILE

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY, **PLEASE PRINT CLEARLY**. YOU MUST FILL OUT THIS FORM COMPLETELY BEFORE YOUR CONSULTATION.

PATIENT NAME: ________________________________ TODAY'S DATE: ______________

STREET ADDRESS: ____

CITY: ______________________________ STATE: ___________ ZIP: ______________

HOME PHONE: ____________CELL PHONE: _____________WORK PHONE: _____________

E-MAIL ADDRESS: ______________________________

DATE OF BIRTH: ______________PARENT/GUARDIAN (IF UNDER 18) ____________________

WHAT IS YOUR NATIONAL ORIGIN/ETHNIC BACKGROUND? _____________________________

HOW DID YOU HEAR OF US? ____

NAME OF YOUR PHYSICIAN: _________________________ PHONE#: _________________

ARE YOU A PATIENT OF WATER'S EDGE DERMATOLOGY? _____YES _____NO

IF YES, WHO DO YOU SEE? ____

FACIAL SKIN TYPE:

OILY: _______ DRY: ________ SENSITIVE: _______ COMBINATION: ______ OILY WHERE? __________

DO YOU TAN EASILY? ______________________ BURN? ___________________________

CONCERNS	OFFICE NOTES
__ SUNDAMAGE	____________________
__ BROWN SPOTS (UNEVEN SPOTS)	____________________
__ UPPER LIP – DEEP { } FINE { }	____________________
__FRECKLES	____________________
__ WRINKLES – DEEP{ } FINE{ }	____________________
__BLACKHEADS{ } WHITEHEADS{ }	____________________
__ HARD BUMPS UNDER THE SKIN	____________________
__ CLOGGED PORES	____________________
__ EXCESSIVE OILINESS	____________________
__ ACNE	____________________
__ MILIA	____________________
__ PIMPLES OFTEN{ } SOMETIMES{ }	____________________

WHAT EXPECTATIONS DO YOU HOPE TO ACCOMPLISH FROM THIS CONSULTATION/TREATMENT?

____

ACNE IN FAMILY? ____

HAVE YOU RECEIVED CORRECTIVE SKIN CARE TREATMENTS BEFORE? Y / N ________________

DERMATOLOGIST________________ AESTHETICIAN___________________________

COMMENTS____

ANY PRIOR COSMETIC SURGERIES, PEELS OR SERVICES: ___FACE LIFT ___ LASER ___ TCA ___PHENOL
___ JESSNER ___ OBAGI ___ IPL ___ THERMAGE ___ OTHER_________ DATES: ___________________________
ARE YOU HAVING HAIR REMOVAL? Y / N______WAXING_________ELECTROLYSIS__________________
OTHER____ DATE OF LAST TREATMENT:____________________
DO YOU HAVE REGULAR FILLER (JUVEDERM, RADIESSE, ETC.) / BOTOX INJECTIONS? _________________
DATE OF YOUR LAST TREATMENT? ____

PRESCRIBED MEDICATIONS (PAST & PRESENT)

ANTIBIOTICS Y / N ____
ANY OTHER MEDICATIONS? Y / N ____
WHAT KIND?____
SIDE EFFECTS?____
ACCUTANE? Y / N _______________WHEN?___________ HOW LONG?____________________________
SULFUR? Y / N __________ PEELING? Y / N ________ EVER USED BENZOYL PEROXIDE? Y / N_____________
PRESCRIBED BENZOIC?____
EVER USED RETIN-A, RENOVA, DIFFERIN OR TAZORAC? _____________________________________
CREAM?__________________________ GEL?________________________ STRENGTH__________________
OVER THE COUNTER PRODUCTS?
BRAND NAMES____
HAVE YOU EVER USED A "BLEACH CREAM" OR "FADE CREAM"? Y / N______________________________
DID YOU HAVE AN ALLERGIC REACTION TO THE BLEACH OR FADE CREAM?_________________________
ANY ALLERGIC REACTION TO ANY MEDICATIONS, PRODUCTS, FOODS, ETC.__________________________
DO YOU CONSIDER YOUR SKIN SENSITIVE?____
PLEASE EXPLAIN:____
ARE YOU USING ANY PRODUCTS CONTAINING THE FOLLOWING? ___ VITAMIN A OR C
___ RETINOL ___OBAGI ___ ALPHA- HYDROXY ACIDS ___GLYCOLIC ___SALICYLIC ___HYDROQUINONE
OTHER BLEACHING PRODUCT? ____
PLEASE CHECK THE PRODUCTS YOU ARE CURRENTLY USING AND LIST THE BRAND NAMES:

CLEANSER{ }______________________________ SOAP{ }______________________________
MOSITURIZER{ }___________________________ NIGHT CREAM{ }________________________
EYE CREAM{ }_____________________________ SUNSCREEN{ }__________________________
SCRUB{ }_________________________________ TONER{ }______________________________
OTHER{ }_________________________________

PLEASE CHECK ANY HEALTH CONDITIONS WHICH YOU HAVE HAD OR ARE NOW EXPERIENCING?

___PSORIASIS ___ECZEMA ___HYPOGLYCEMIA ___HEPATITIS
___PREGNANCY ___HYSTERECTOMY ___HIGH/LOW BLOOD PRESSURE ___CANCER
___DIABETES ___HEART PROBLEM ___METABOLIC DISORDERS ___ASPIRIN SENSITIVE
___SEBORRHEA ___ALCOHOLISM ___THYROID (UNDER/OVER) ___HERPES & COLD SORES
___HORMONAL PROBLEMS ___OTHER_______________________

WOMEN ONLY

PREGNANT{Y / N}____BREAST FEEDING{Y / N}____PREMENSTRUAL{Y / N}____________________

BREAKOUTS{Y / N}____REGULAR PERIODS{Y / N}____BIRTH CONTROL PILL{Y / N}____________________

HOW LONG? YEARS, MONTHS_______ SAME BRAND AS LISTED ABOVE{Y / N} ____________________

ARE YOU ON HORMONE REPLACEMENT THERAPHY{Y / N}____________________

PATCH OR PILL____________________ BRAND AND STRENGTH____________________

YOUR LIFESTYLE

DO YOU SMOKE? ____________________

TYPE OF WORK? ____________________

STRESS LEVEL: HIGH____ MED____ LOW_____

DO YOU WORK AROUND CHEMICALS. TAR, OIL, ETC...?____________________

HOURS OF SLEEP PER NIGHT / DAY____________ WATER INTAKE(GLASSES PER DAY)____________________

VITAMINS (PLEASE LIST ALL): ____________________

HOW OFTEN? ______________ DO YOU EXERCISE STRENUOUSLY {Y / N}____________________

STEROID USE {Y / N}__________ DO YOU PICK YOUR OWN ACNE LESIONS {Y / N}____________________

ANYTHING ELSE WE SHOULD KNOW ABOUT? ____________________

PATIENT SIGNATURE: ____________________ **DATE:** ______________

PRINT NAME: ____________________

PARENT/GUARDIAN SIGNATURE (if under 18): ____________________ **DATE:** ______________

PRINT NAME: ____________________