ADVANCED AESTHETICS
IN ASSOCIATION WITH ARKANSAS PLASTIC SURGERY

PATIENT CONSULTATION FORM

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Date: _____ Please contact me by: ☐ Phone ☐ Mail ☐ E-Mail

PERSONAL INFORMATION

Name _____ DOB _____ Sex F__ M__

Address_____ Phone (H)_____(W)_____(C)_____

City _____ State ___ Zip Code _____

E-mail address (optional) _____

Referral Source _____
(be specific: Name of friend, T.V., patient, doctor, website, newspaper, etc.)

Reason for Consultation: _____

Medical Information Primary Care Physician _____

CIRCLE ONE:
Hair Color (blonde, red, light brown, dark brown, black, gray)

Eye Color (blue, green, hazel, brown, black)

Skin Tone (pink, peach, olive, Native American, Hispanic, Asian, Black)

Please circle any health conditions you may have: Cancer, Claustrophobia, Diabetes, Epilepsy, Heart Disease, High or Low blood pressure, pacemaker, auto-immune disease

Women ONLY: Are you pregnant or lactating? Yes or No
Have you experienced menopause? Yes or No
Do you suffer from PMS? Yes or No

Everyone:

Please circle if you have had any of the following: Hives, Herpes, cold sores, fever blisters, keloids.
When? _____

Please list all medications you take internally/orally including Thyroid, HRT/BCP, Accutane (when last taken?) _____

Please list any medications that you regularly use topically including Retin-A, AHA's, etc.
_____

Please list all surgeries, including cosmetic and when:
_____

Please list any allergies or allergic reactions:
_____

Life Style Information:

What is your level of stress (1 low, 10 high) _____
How many hours of sleep do you get per night (estimated) _____
Vitamin or mineral supplements taken _____
Caffeine daily intake (cups) _____
Do you salt your food _____
How much alcohol do you drink daily _____
Are you on a diet (specify) _____
How much milk do you drink daily _____
How much water do you drink a day _____
Are you a vegetarian _____
Do you smoke _____ How much _____
Do you exercise _____
Do you use a tanning bed _____
Circle sun exposure : A lot Average Minimal

Please list the brand of products you are currently using. Do any of these include Glycolic type acids?

Cleanser _____ Toner _____
Moisturizer _____ Scrub _____
Mask _____
Other _____

Do you suffer from any of the following: Please Circle

Whiteheads	Blackheads	Oily Complexion	Acne- Where?
Rosacea	Eczema	Psoriasis	Fine Lines
Wrinkles	Age Spots on hand s	Brown Spots	White Spots
Moles	Broke Capillaries	Warts	Ingrown Hairs
Dry Scalp	Dehydration	Flaky Skin	Enlarged Pores
Skin Cancer	Sensitive Skin	Dry	Rough
Cellulite	Varicose Veins	Spider Veins	

Have you ever experienced the following:

Professional Facials	Glycolic Peels	Salicylic Peels	Jessners Peels
TCA Peels	Phenol Peels	Microdermabrasion	Medical Dermabrasion
Endermologie	Lash/Brow Tints	Make-overs	Vein Treatments
Laser Hair Removal	Waxing (brows, lips, legs, bikini)		

What specific areas do you want to treat? _____

What do you hope to achieve from this consultation? _____

What are your goals for your future skin care program? _____

Directions: Take Exit 7 off -630 to stop sign. Turn Left on Baptist Health Drive and follow Baptist Health Drive to Emergency Drive and turn right. Turn right off Emergency Drive into parking lot nearest Hickingbotham Outpatient Center, or enter the parking lot from Kanis Road. Take elevator inside the Hickingbotham Outpatient Center to the fifth (5th) floor, Suite 503. Advanced Aesthetics is located next door to Arkansas Plastic Surgery.