DERMATOLOGY, P.C.

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West Des Moines, IA 50266
515-241-2000

800 E. 1st Street #E260
Ankeny, IA 50021
515-963-9639

2006 N. 4th Street #100
Indianola, IA 50125
515-961-3880

Patient Name:_____ Date of Birth:_____

What are your cosmetic concerns? (Check all that apply)

☐ Scarring	☐ Thin lips	☐ Facial redness	☐ Hair reduction
☐ Fine lines / wrinkles	☐ Blotchy skin	☐ Brown spots	☐ Skin texture
☐ Facial folds / loss of fat	☐ Facial or Leg veins	☐ Longer eye lashes	☐ Chin/neck fat

Other:_____

Which treatment(s) interests you?

☐ BOTOX® Cosmetics / Dysport	☐ Chemical Peels	☐ Intense Pulse Light (IPL) (Hair reduction)
☐ Dermal Fillers	☐ FRAXEL fractional laser (Brown spots / Acne scars)	☐ Cutera Laser (Brown spots / Red spots & lines)
☐ Microdermabrasion	☐ Sclerotherapy (leg veins)	☐ Kybella (Chin fat reduction)

What prescription(s) and/or over-the-counter products are you using on your skin:

_____ _____

_____ _____

_____ _____

What cosmetic procedures, if any, have you had in the past? _____

_____

_____

If yes, were you pleased with the results? _____

_____

When was the last time you had a full body skin examination? _____

Do you have any history of skin cancer? Y / N

Are you currently pregnant or nursing? Y / N

Have you ever had a cold sore, shingles or herpes? Y / N

Are you currently using a topical retinoid (tretinoin, Retin-A, Renova, Differin)? Y / N _____

Are you taking or have you ever taken Accutane (Isotretinoin)? Y / N When:_____

Do you smoke or use tobacco? Y / N If so, how many per day?_____

How much direct sun are you exposed to daily? _____

How did you hear about our practice?_____

Would you like to be notified of our new services or specials? If so, please provide email address:_____

_____ _____

Patient Signature Date