



# NOVA COSMETIC CENTER CONSULTATION FORM

Name: \_\_\_\_\_ Consultation Date: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

e- Mail Address: \_\_\_\_\_ Work Number: \_\_\_\_\_

Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Female  Male

How Did You Hear About Us? \_\_\_\_\_

If Referred, Whom May We Thank? \_\_\_\_\_

May We Mail/e-Mail You With Newsletters And Notices? Yes  No

Where May We Call To Confirm Your Appointments? Work  Home  No Calls

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

## Please Check Procedures You Are Interested In:

- Cellulite Therapy  Chemical Peels  Customized Facials  Microdermabrasion  
 Photofacials  Skin Tightening  Detox Treatments  Skin Care Consult  
 Elimination Of Excessive Sweating  Varicose/Spider Veins Therapy  
 Permanent Make-Up  Mesotherapy  Lipo-Dissolve  Botox®  
 Dermal Fillers  Cosmetic Surgery  Other \_\_\_\_\_

## Hair Reduction Areas:

- Upper Lip  Chin  Cheeks  Neck  Glabella  Ears  Hands  Feet  Chest  
 Underarms  Forearms  Upper Arms  Full Arms  Abdomen  Flanks  Breast  
 Back  Shoulders  Buttocks  Thighs  Lower Legs  Full Legs  Bikini  
 Mens Bikini  Nose  Hair Line  Other \_\_\_\_\_

Circle Current/Prior Method Used: Waxing Shaving Tweezing Electrolysis Topical Depilatory

Current Skin Care Regimen: \_\_\_\_\_

Describe Your Goals And Expectations:

\_\_\_\_\_

Treatment Concerns:

\_\_\_\_\_

# MEDICAL HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Treatment/s of Interest: \_\_\_\_\_

## Please describe your skin's response to sun exposure:

- Type I - Always burns, never tans
- Type II - Usually burns, tans with difficulty
- Type III - Sometimes mild burn, gradually tans
- Type IV - Rarely burns, tans with ease
- Type V - Very rarely burns, tans very easily
- Type VI - Never burns, tans very easily

## SKIN TYPE EVALUATION

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

When was your last sun or tanning bed exposure to the area being treated? \_\_\_\_\_

When was the last time you used self-tan in the area being treated? \_\_\_\_\_

What is your true hair color? \_\_\_\_\_

Do you have any birthmarks? \_\_\_\_\_ where? \_\_\_\_\_

Please list any known medication allergies: \_\_\_\_\_

Please list any known skin care allergies: \_\_\_\_\_

Please list any over the counter or prescription medication that you are currently taking:

\_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_

Are you allergic to latex? \_\_\_\_\_

Have you ever had a cosmetic peel? If so, when? \_\_\_\_\_ what kind? \_\_\_\_\_

## Please check if you are currently using or have used any of the following:

- Renova  Retin-A  Differin  Accutane  Hydroquinone  Avage  Tretinoin

Are you currently on Hormone Replacement Therapy or HGH? \_\_\_\_\_

Please list any surgical or cosmetic procedures you have had in the last 24 months:

\_\_\_\_\_

Please list any medical condition for which you are currently seeking Physician care:

\_\_\_\_\_

Do you have any metal implants (pace maker, pin in bone, copper IUD) \_\_\_\_\_

**For women only:**

Are you currently pregnant, trying to conceive or breast feeding?  Yes  No

Are you taking oral contraceptives?  Yes  No If so, how long? \_\_\_\_\_

Do you have Melasma a/k/a mask of pregnancy?  Yes  No

**Please check if you have or had any of the following conditions:**

- Unusual Cystic Acne Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Burns/Grafted Skin Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Psoriasis/Grafted Skin Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Herpes (Type I or II) Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Melanoma/Skin Cancer Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Keloid/Thick Scars Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Hirsutism (Diagnosed) Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- High Blood Pressure Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_
- Kidney Disease Current Treatment: \_\_\_\_\_
- Lupus Erythematosus Current Treatment: \_\_\_\_\_
- Diabetes Current Treatment: \_\_\_\_\_
- HIV Current Treatment: \_\_\_\_\_
- Cancer Current Treatment: \_\_\_\_\_
- Steroid/Hormone Therapy Current Treatment: \_\_\_\_\_
- Depression (Diagnosed) Current Treatment: \_\_\_\_\_
- Hepatitis (A, B or C) Current Treatment: \_\_\_\_\_
- Other: \_\_\_\_\_ Location: \_\_\_\_\_ Current Treatment: \_\_\_\_\_

**Please circle any skin conditions:**

Freckles Blackheads Sun Damage Sensitive Skin Enlarged Pores Acne Whiteheads Dry Oily

Brown Spots Uneven Pigmentation Wrinkles Other: \_\_\_\_\_

**Skin care regimen:**

Please describe your daily skin care regimen, including the name brand of all products used:

\_\_\_\_\_

By signing below, I attest that the information disclosed in the Medical History is accurate to the best of my knowledge.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Aesthetician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Consent to Photograph

In connection with the medical services which I am receiving from Jan V. Karlin, M.D. and/or his associates, I, the undersigned, do hereby authorize the above named surgeon to photograph or permit others to photograph before and after my treatment/procedure.

Under the following conditions:

- 1) The photographs may be taken only with the consent of my physician/surgeon and under such conditions and at such times as may be approved by him.
- 2) The photographs shall be taken by my physician/surgeon or by his assignee.
- 3) These photographs shall be used for medical record only, unless in the judgment of my physician, medical research, education, promotion, and/or science will benefit from their use.
- 4) In the event the photos are used for medical research, education, promotion, and/or science, my identity will be omitted.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent if patient is a minor: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# Statement of Understanding

I agree that the determination of professional services to be rendered by my Doctor and the fees to compensate him for these services are matters concerning my Doctor and me. I understand that I have the primary duty and obligation to pay my Doctor for his services. Notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like.)

Neither my Doctor nor I will permit any third party to determine what medical services I need or what fees the Doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our Doctor-Patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I as the Patient are in any way bound by any contract the other may have with any third party.

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_