PLASTIC SURGERY ASSOCIATES
ANSON · EDWARDS · HIGGINS

Areas of Concern

Patient's Name ______________________ ______________________ __________
Last First Date

What are your main concerns for today's visit?

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Please check the problem areas that concern you. Include anything you wish to discuss, even if it is not the main reason for your visit.

Face/Eyes/Neck
- ☐ Aging Face/Neck
- ☐ Aging Brow/Forehead
- ☐ Excess Eyelid Skin
- ☐ Botox
- ☐ Facial Fillers (Juvederm, Voluma, Restylane, Sculptra, ETC)
- ☐ Wrinkles/Fine Lines
- ☐ Kybella
- ☐ Skin Texture
- ☐ Skin Pigment
- ☐ Dark Circles
- ☐ Laser Treatments
- ☐ Chemical Peels
- ☐ Eyelash Growth (Latisse)

Ears
- ☐ Prominent
- ☐ Ear Lobes

Nose
- ☐ Difficulty Breathing
- ☐ Shape or Bump
- ☐ Crooked

Breast/Chest
- ☐ Breast Size
- ☐ Breast Asymmetry Correction
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Breast Implant Revision
- ☐ Pectoral Implants (Men)
- ☐ Nipple/Areola Concerns
- ☐ Gynecomastia

Excess Skin
- ☐ Abdomen
- ☐ Thighs
- ☐ Arms

Liposuction
- ☐ Abdomen
- ☐ Bra Rolls
- ☐ Hips/Flanks
- ☐ Inner Thighs
- ☐ Outer Thighs
- ☐ Knees
- ☐ Calves
- ☐ Coolsculpting

Gynecological
- ☐ Excess Labia Tissue

Skin
- ☐ Scars
- ☐ Moles
- ☐ Acne
- ☐ Rashes
- ☐ Warts

Other Concerns
- ☐ Excess Sweating (Botox)
- ☐ Hand Treatments
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

Provider Recommendations:

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I verify that I have provided all of my medical and surgical history to ensure my physician has all the important information to provide the safest care. I will update any new information that occurs in-between visits to include new diagnoses, new medications, subsequent surgeries and any hospitalizations.

______________________________ ______________________________
Signature Date

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Skin Treatment Evaluation

Patient's Name ____
Last First Date

How would you like improve your skin? ____

Rate your satisfaction with your skin's overall appearance at this time on a scale of 1 – 10: ______________

Do you have any health problems? ☐ Yes ☐ No If yes, please explain: ______________________________

____

List all current medications, antioxidants, vitamins, or herbal supplements you are taking: ______________

____

Do you smoke? ☐ Yes ☐ No if yes, how many packs per day? ______________________________

Do you have any drug or food allergies? ☐ Yes ☐ No if yes, please explain: ______________________

____

Are you pregnant or breastfeeding or are you trying to get pregnant? ☐ Yes ☐ No

Please list any diagnosed skin conditions including date of diagnosis and treatment: ______________

____

Do you have a history of skin cancer? ☐ Yes ☐ No if yes, list location, diagnosis, date, and type of treatment:

____

Do you have a history of cold sores? ☐ Yes ☐ No If yes, how frequently? ______________________

Do you have a history of keloid or hypertrophic scarring? ☐ Yes ☐ No if yes, please explain ____________

____

<u>Skin Type</u>

Please check below what best describes your skin type:

☐ very fair skin, always burns ☐ fair skin, usually burns ☐ light skin burns first, then tans ☐ medium skin, usually tans
☐ dark skin, never burns ☐ browns spots ☐ broken capillaries

Do you consider your skin to be: ☐ normal ☐ oily ☐ dry ☐ combination/T-Zone

Facial Wrinkles: ☐ none ☐ deep wrinkles ☐ crows feet ☐ fine lines

Have you or are you currently experiencing Acne problems/breakouts? □ Yes □ No

If yes, how often do you breakout? □ always □ occasionally □ never

Check all that apply: □ pimples □ whiteheads □ blackheads □ enlarged pores □ acne scars □ cysts

Have you taken the acne medication Accutane? □ Yes □ No if yes, when? ______________________________

Do you consider your skin to be Sensitive? □ Yes □ No if yes, please describe: ______________________________

____

Sun Exposure

How many hours are you exposed to the sun? □ daily □ weekly

Do you travel to or live in high altitudes or near water? □ Yes □ No

Do you wear sunscreen daily? □ Yes □ No if yes, what SPF? ______________________________

Do you wear sunscreen while outdoors? □ Yes □ No if yes, what SPF? ______________________________

Do you sunbathe or use a tanning bed? □ Yes □ No

Do you use self tanner? □ Yes □ No

Treatment History

Have you previously had any of the following: □ chemical peels □ laser resurfacing □ IPL □ fraxel □ facial surgery □ microdermabrasion □ glycolic acid treatments

Type of procedure and dates: ______________________________

____

Have you had any facial hair removal treatments such as waxing, laser hair removal, or used depilatories in the last 4 weeks? □ Yes □ No

Please explain your current skincare regimen and brands of skin products used:

A.M. ______________________________

P.M. ______________________________

How long have you been following the above regimen? ______________________________

Are you satisfied with your current products? □ Yes □ No

Do you currently use Retinol creams, Retin A, Renova, AHA or Glycolic topical preparations? □ Yes □ No if yes, explain

strength and frequency: ______________________________

Treatment Plan

How much irritation, redness, dryness, flaking and possible breakouts are you willing to tolerate during this rejuvenation process? ☐ none ☐ mild ☐ moderate

Are you looking for a more gradual transformation with little or no irritation from your home care and professional treatments or a more rapid transformation with more irritation and possibly more down time?

☐ gradual transformation ☐ rapid transformation

How many minutes can you commit to your skin care routine? A.M.: _____________ P.M. : _____________

Aesthetician Light Chemical Peel/Dermaplane/Microdermabrasion/Extractions, Informed Consent

Patient's Name ______________________ ______________________ ____________
Last First Date

Various techniques are used by Aestheticians to provide specific treatments to the skin and for exfoliation. They are performed to treat a variety of skin conditions including sun damage, uneven pigmentation, and texture. Extractions of blackheads and whiteheads (comedones) are often included during treatments. The degree of peeling depends on the agents, length of downtime planned, and individual skin response. Results of the treatment are variable and depend on age, condition of skin, degree of sun damage, smoking, climate, etc. Repeated treatments are generally recommended to maximize their effects. These treatments should be considered part of an overall skin care regimen that includes daily topical agents and sun avoidance.

For your safety, you must

- Make us aware if you get Cold sores / Fever blisters (Herpes simplex virus).
- Make us aware if you have any allergies, including to any topical creams.
- Discontinue use of any Retinol products for 5 days prior to the treatment-- Unless otherwise instructed.
- Make us aware if you use: Glycolic acid, Retinols, Renova, and Retin-A.
- Make us aware if you take: Hormone replacement, Birth control pills, Accutane.
- Make us aware if you have had recent facial surgery, fillers (Juvederm, Restylane, etc.).
- Avoid sun exposure and tanning for 14 days after treatment.
- Agree to use sun block (SPF 30 or higher) regularly, but especially after the treatment.
- Follow the post-treatment instructions to avoid complications.

Alternatives to Light Chemical Peels / Dermaplaning / Microdermabrasion include: laser therapies, other chemical peels, dermabrasion, and topical therapies. Although complications are rare, below are potential risks. It is important to contact us if you have any concerns about your post-treatment healing

Discomfort
Mild stinging, heat or tightness may be felt during and for a short time after the treatment.

Peeling
Flaking of skin is sometimes desired depending on the exact treatment performed. Peeling can persist for 1-7 days. Be aware that some peels may not dramatically 'peel' due to the condition of the skin prior to the treatment or current home care products being used. The amount of visible peeling is NOT an indicator of the effectiveness of the treatment.

Redness
Redness is often present for a few hours. Longer periods of redness should be expected if a deeper treatment is performed.

Spot Treatments
With your permission, spot treatments on deeper lesions (brown spots, lentigines) may be used. These may be a deeper 'burn' requiring 3-7 days of healing. Once healed, these areas can remain pink for 6 weeks or longer. Sun block is critical in this area.

Cold Sores (Fever Blisters, Herpes Simplex Virus)
These treatments can precipitate a new outbreak. It can aggravate or spread an active outbreak. If any active lesions are present (or impending), you will need to reschedule your appointment. In patients with very frequent outbreaks, pre-treatment with an anti-Viral Medication (Valtrex, Acyclovir) May Be Considered.

Changes in Pigmentation
Undesirable changes in color can occur due to scarring. Scarring could result from the 'burn' going deeper than intended. Increased depth is most likely to occur with an infection. INFECTIONS are rare but adherence to instructions is very important.

Dermaplaning Note
Rarely, a 'nick' in the skin can occur, as with shaving. This is unlikely, but heals in a day or two. Dermaplaning shaves off the fine facial hair. When the hair grows back, it is blunt ended. New hair will NOT appear darker or denser due to the Dermaplaning. Unrelated hormonal changes can affect hair growth patterns.

I authorize the treatments outlined. I have had all my questions answered to my satisfaction.

______________________________ ____________
Signature Date

______________________________ ____________
Witness Signature Date

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Patient Registration Information

Patient's Name ______________________ ______________________ ______________
Last First Date

Birthdate: ___/___/_____ Age: _________ Gender: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced

E-mail: ______________________________

Address: ____
Street & Apt # City State Zip

Cell Phone: __________________ Home Phone: __________________ Work Phone: __________________

Which phone do you prefer we use to contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Any restrictions for contacting you? (Ok to call at work? Leave message at home?,etc.) ______________________

May we use your email to send useful information, updates, promotions and event info? We promise not to abuse it! ☐ Yes ☐ No

We offer 2 methods of appointment reminders, please check your preference (one): ☐ Text Message ☐ Email

For minors, who is the authorized adult or responsible party? ______________________________

Patient's Employer: ____________________________ Occupation: ____________________________

Address: ____
Street & Suite # City State Zip

Emergency Contact: ________________________ Relationship to Patient: ________________________

Home Phone: __________________ Work Phone: __________________ Other Phone: __________________

Address: ____
Street & Apt # City State Zip

Insurance Information
Do you have medical insurance? ☐ Yes ☐ No Insurance Provider ______________________________
*Although we do not take insurance, this information will assist in coordinating your care.

Pharmacy Information
In the event we need to send a prescription to your pharmacy electronically, please provide your pharmacy information:

Pharmacy __________________ **Cross Streets** ______________________________ **Phone** __________________

Referral Information
Who referred you to our practice? ____

May We Thank Them Using Your Name? ☐ Yes ☐ No

If Not Referred How Did You Hear About Us? ☐ Website __________________ ☐ Magazine __________________

☐ Other ________________________