



EAST LAKE
PLASTIC SURGERY CENTER

SKIN CARE SERVICES CLIENT INFORMATION

Date _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a Minor: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Phone #: (home) _____ (work) _____ (cell) _____

Occupation _____

Notify in Case of Emergency: _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

How did you here about us? _____

Microdermabrasion and **Chemical Peels** should be avoided in individuals with HIV, uncontrolled diabetes, suspected TB or who are pregnant/lactating or trying to become pregnant. Is there a possibility that you may have one of these conditions? Yes No

Have you had BOTOX® or Collagen injections within the last two (2) weeks? Yes No

Have you undergone Laser Resurfacing within the past twelve (12) weeks? Yes No

Have you had a glycolic, salicylic or TCA peel within the past eight (8) weeks? Yes No

Are you currently taking any of the following medications? Coumadin Accutane Aspirin

Have you ever experienced an allergic reaction to latex? Yes No

Are you experiencing any problems or concerns with the skin care program that you are currently following?
Yes No If yes, please explain: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____



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SKIN CARE EVALUATION

Date _____

Account # _____

1. Have you ever seen a dermatologist or plastic surgeon for your skin? YES NO
2. Are you currently under a physician's care? YES NO Reason: _____
3. Have you ever used Accutane? YES NO
4. Have you ever had a skin allergy? (i.e. cosmetics, fabrics, latex, salicylic, or glycolic acids, etc) YES NO
If yes, please explain: _____
5. Do you have any medication allergies? YES NO
If yes, please explain: _____
6. Are you pregnant, lactating or planning to become pregnant? YES NO
7. While pregnant, did you get hyperpigmentation or masking? YES NO
8. Are you going through menopause? YES NO
9. Do you wear contact lenses? YES NO
10. Do you exercise regularly? YES NO Do you take Vitamins? YES NO
11. Do you smoke? YES NO If not, were you ever a smoker? YES NO How long? _____
12. Do you have broken capillaries? YES NO If yes, please indicate where: _____
13. Do you have acne or periodic breakouts? YES NO
 Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars
14. Do you have: Deep Wrinkles Crows Feet Fine Lines
15. Skin Type (Fitzpatrick Classification) Please circle the category that you feel best describes you
I- Always burn, never tan IV- Never burn, always tan
II- Always burn first, then tan V- Hispanic, Asian, Mediterranean, Middle Eastern
III- Sometimes burn, sometimes tan VI- Black
16. What percentage of time do you spend in the sun? Summer _____% Winter _____%
17. Do you use a sunblock when outdoors? YES NO What SPF do you use? _____
18. Do you use chemical self-tanning lotions? YES NO Tanning beds? YES NO
19. Have you or members of your family had skin cancer? YES NO Location: _____
20. Do you form thick or raised scars from a cut or burn? YES NO
21. Current hair removal treatment: Bleach Electrolysis Wax Pluck Shave
22. How sensitive is your skin? _____
23. Do you or have you ever had any of the following:
 Keloid scarring Hepatitis Dermatitis Excema Acne scarring Herpes Simplex
 Skin Cancer HIV+ Other (please specify) _____
24. Have you ever had any of the following treatments: Chemical Peel Glycolic Peel Laser Peel
 Collagen Botox Cosmetic surgery Other (please specify) _____
25. What products are you presently using? _____
26. Do you use or have you ever used any of the following products? If so, when?
 Retin-A Retinol AHA Hydroquinone Accutane Renova
 Metrogel Differin BCP Other _____
27. Which conditions would you like to improve? Hyperpigmentation Sun Damage Acne scarring
 Age spots Fine lines and wrinkles Acne # of months ___ years _____ Surgical/Facial scars
 Enlarged pores Stretch marks Other (please specify) _____
28. Areas to be treated: (Please detail entry) _____

