Please Write Legibly
Print Only

SKIN SECRETS
FACIAL PLASTIC SURGERY & MEDICAL SPA

Dale B. Smith, D.O.
Board Certified Facial Plastic Surgeon

Name: _____ **Birth Date** : _____ **Age**: ____ **Gender: Male__ Female__**

Home Phone: _____ Work: _____ Cell: _____

Address: _____ **City: _____ State: _____ Zip: _____**

Emergency Contact: _____ Phone: _____

Email: _____ Join our email list: ❑yes ❑no **Occupation: _____**

Y N Are you currently under the care of a physician? If yes, for what: _____
Y N Are you currently under the care of a dermatologist? If yes, for what: _____
Y N Do you suffer from any chronic skin conditions? (example: Acne) If yes, what type: _____
Y N Do you wear sunscreen daily?
Y N Are you currently under a lot of stress?
Y N Do you smoke?
Y N Are you currently pregnant or breastfeeding?
Y N Have you ever used Accutane? (prescription medication to treat certain skin diseases/acne)
Y N Do you use a tanning bed?
Y N Are you currently using Retin-A, Retinol, Glycolic Acid or any other skin exfoliating products or prescriptions?
Y N Do you have implants/stents in the facial area? (metal stents, implanted electrical devices, mechanical or other implants)
How much sleep do you get per night? _____ (hours)

Are you or have you experienced any of the following health conditions:

___ Diabetes	___ Glaucoma	___ Sinus Problems	___ Keloid Scarring	___ Tuberculosis	___ HIV/AIDS	___ Bell's Palsy
___ Contact Lenses	___ Sensitive Eyes	___ Shingles	___ Hepatitis	___ Laser Resurfacing	___ Mental Disease	___ Autoimmune Disease
___ Sensitivity to Soap	___ Skin Lesion	___ Fever Blisters/Herpes	___ Bleeding disorder	___ Chemical/Acid Peel	___ Cosmetic Surgery	___ Migraines
___ Hormone Imbalance	___ High Blood Pressure	___ Thyroid Imbalance	___ Epilepsy	___ Anxiety Attack	___ Cancer	___ Other

What is your skin type? ___Normal ___Oily ___Combination ___Dry

Have you ever had a reaction or sensitivity to a skincare product or treatment? If yes, please explain.

_____
_____

Please list all skincare products you currently use.

_____
_____

Please list any facial treatments you have had in the past.

_____
_____

Please list ALL medications you are currently taking (vitamins, OTC, aspirin, birth control, etc.)

_____
_____

Please list ALL known allergies (food, drug, animal, product, latex, etc.)

_____

Please list ALL surgeries you have had and date of surgery (removal of teeth, child birth, etc.)

_____
_____

How did you hear about us? (circle one)
Friend/Family (name of referring person/s):_____ Newspaper TV commercial Website Phonebook Facebook Billboard Magazine

Salon(name of salon): _____ Other (please describe): _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that is it my responsibility to inform the Esthetician, Doctor, Nurse, or other Staff of my current medical or health conditions and when such conditions change.

Signature: **(must be signed)** _____ Date: _____

Esthetician: _____ Date: _____

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