Desert Medical Rejuvenation

Art Quintanilla, MD
Board Certified Physician

DERMASWEEP Patient Consultation and History Form

Patient Name: _____ Address: _____

Birth Date: _____ Telephone Number: _____

Have you ever seen a dermatologist for your skin?	Yes	No
Are you pregnant?	Yes	No
Have you used Accutane?	Yes	No

What topical medication do you use or have you used?

Retin-A Glycolic Lactic Acid Other: _____

What oral medication have you used or do you currently use?

Antibiotics Hormones or Birth Control Diuretics Other: _____

Have you had skin acid peels?	Yes	No
Have you ever had laser surgery or dermabrasion?	Yes	No
Have you ever had collagen injection?	Yes	No

How often? _____

Where? _____

Have you ever had a microdermabrasion treatment?	Yes	No
Do you get facials?	Yes	No

What type of skin care products do you currently use?

_____

Hypersensitivity & Fragility

Have you ever had a skin allergy?	Yes		No
Do you have any known drug allergies?	Yes		No
Do you experience any claustrophobia?	Yes		No
What type of massage do you prefer?	Light		Firm
What level do you consider your pain threshold to be?	High		Low
What temperature of water do you use to cleanse?	Cool	Warm	Hot

FREE RADICAL EXPOSURE

Do you smoke?	Yes	No
Do you consume alcohol?	Yes	No

Do you have regular diet?	Yes	No
Do you exercise?	Yes	No
Do you take vitamins?	Yes	No
How much water do you consume daily?	_____	
Do you take laxatives or diuretics?	Yes	No

HORMONES

Do you have regular periods?	Yes	No
Are you going through menopause?	Yes	No
During pregnancy, did you get hyperpigmentation or masking?	Yes	No
Are you taking oral contraception?	Yes	No
Are you trying to become pregnant?	Yes	No
Are you currently having or due for your menstrual period?	Yes	No

SUN HISTORY & LIFESTYLE

What percentage of time do you spend in the sun?	Yes	No
In the past have you lived in a sunbelt and sunbathed?	Yes	No
In the past have you neglected to use sun block?	Yes	No
Do you go to tanning salon?	Yes	No
Circle your level of stress (1 low, 10 high)	1 2 3 4 5 6 7 8 9 10	
Do you now or at any time in the past get cold sores or herpes?	Yes	No
Have you or any member of your family had skin cancer?	Yes	No

SKIN TYPE

Does your skin ever flake or feel tight and dry	Frequently	Occasionally	Rarely
Is your skin ever shiny a few hours after cleansing?	Frequently	Occasionally	Rarely
How often do you experience blackheads or blemishes?	Frequently	Occasionally	Rarely
How noticeable are your pores?		Very	Not Very

FITZPATRICK CLASSIFICATION SYSTEM (SELECT ONE SKIN TYPE BELOW WHICH BEST SUITS)

Skin Type:	Skin color:	Characteristics:
I	White	Always burns, never tans
II	White	Usually burns, tans less than average
III	White	Sometimes mild burn, tans about average
IV	White	Rarely burns, tans more than average
V	White	Rarely burns, tans profusely
VI	White	Never burns, deeply pigmented

PIGMENTATION

Is your pigmentation:	Even	Uneven	Birthmark	Pregnancy	Mask

VASCULARITY

Broken Capillaries:	Nose	Cheeks	Chin	Forehead	Entire Face
Do you blush easily?	Yes	No			

ACNE

Do you have any history of acne or periodic breakouts?

_____

_____

_____

Rosacea? _____

ABILITY TO HEAL

Does your skin appear fragile?	Yes	No
Do you form thick or raised scar?	Yes	No
Do you have any health problems?	Yes	No
Are you diabetic?	Yes	No
Do you wax or use depilatories?	Yes	No

PATIENT OBJCTIVE:

What specific areas do you want treated? Face___ Neck___ Chest___ Back___ Hands___
Forearms___Other_____

_____

_____

_____

TREATMENT PLAN:

_____

_____

_____