ALLSKIN
DERMATOLOGY
Terri R. Dunn, M.D. Miriam Ferreira, PA-C

Skin Care Consultation Profile

Last Name _____ First_____ Middle _____

Date of Birth _____Address _____

City _____State_____ Zip _____ Home Ph _____Work Ph_____

Emergency Contact _____ Contact #_____ Relationship_____

Email Address:_____

Allergies _____

Current Medication (including vitamins) _____

Oral blood thinners (aspirins) _____ Have you ever used Retin A/Tretinoin? Yes/No ____ % used_____

Have you ever taken Accutane? _____ When _____ Dosage_____ Months _____

Birth control pills? _____ Currently pregnant? _____ Breast feeding? _____

Attempting pregnancy?_____ Hormone Replacement? _____

Permanent Make-up?_____Other? _____

Do you wear contact lenses? _____yes _____no

When overexposed to the sun, would you say your skin tans first? [ ] or your skin burns first? [ ]

Pre-cancerous/cancerous lesions? _____ Lesion removal?_____ When ?_____

Mole removal? _____ When _____ Hair Removal? If so, indicate which of the following methods Wax [ ] Electrolysis [ ] Laser [ ] Shave/Tweeze [ ]

Please indicate which of the following conditions you have or have had:

- ☐ Active Acne (pustules, papules, cysts, boils)
- ☐ Broken Capillaries
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema/Dermatitis/Psoriasis
- ☐ Herpes Simplex Active? Y N
  (❍ Famvir ❍ Zovirax ❍ Valtrex)
- ☐ HIV
- ☐ Hypo/Hyper Pigmentation
- ☐ Lupus Erythematosus
- ☐ Open Areas (cuts) Where?_____
- ☐ Rosacea
- ☐ Skin Cancers – Type_____
- ☐ Vascular Lesions (red birth marks)
- ☐ Vitiligo
- ☐ Warts

PLEASE COMPLETE BACK OF THIS QUESTIONNAIRE)

Previous Facial Resurfacing Procedures *(please give dates)*

C02 _____ Erbium_____ Microdermabrasion_____ Fillers, Facelifts _____

Chemical Peels: Phenol_____ TCA_____ Glycolic_____ Salicylic_____

Botox Injections?_____ Soft Tissue Fillers? _____ Facial implants?_____

Other treatments _____

Names of Home Skin Care Products

Cleanser_____Times/day_____Toner/Astringent _____

Moisturizer_____ Eye Cream_____ Exfoliator _____

Sunscreen _____ Regularity of use _____ SPF _____ Make-up _____

Other _____

Areas of Concerns

Lines/wrinkles [ ] Skin Texture [ ]Skin elasticity [ ] Skin Discoloration [ ] Psoriasis/Eczema [ ]
Acne Scars [ ] Acne (pimples, whiteheads, blackheads) [ ] Skin disorder_____

Other concerns _____

☐ Patient signature _____ Date _____

I have received a copy of the Notice of Privacy Practices for AllSkin Dermatology.

☐ Patient signature _____ Date _____

Office Personnel below this line

Recommendations:

2828 Telegraph Avenue ~ Berkeley, CA 94705
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