Drs. Papel and Kontis
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Suite 370
Baltimore, MD 21208
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Client: _____ Date of Birth: ___/___/__ Today's Date: ___/___/___

Address: _____

Phone: _____ Alternative Phone: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact name & number: _____

How did you hear about us? _____

Reason for Consultation: _____

Are you currently under a physician's care? ( ) YES ( ) NO

Are you allergic to any medications? ( ) YES ( ) NO If yes, please list below:

_____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbs):

_____

_____

Does your medication prohibit exposure to sun or light?	( ) YES	( ) NO
Have you been on Accutane in the past 6 months?	( ) YES	( ) NO
Have you undergone chemotherapy or radiation?	( ) YES	( ) NO
Do you experience herpes or cold sore breakouts?	( ) YES	( ) NO
Do you take aspirin, ibuprofen, vitamin E, or other blood-thinning medication?	( ) YES	( ) NO

If YES, how recently? _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO
High Blood Pressure	( )	( )
Circulatory Problems	( )	( )
Heart Murmur/MVP	( )	( )
Irregular Heartbeat	( )	( )
Phlebitis	( )	( )
Inflammation of Vein	( )	( )
Blood Clots	( )	( )
Pacemaker	( )	( )
Peripheral Vascular Disorder	( )	( )

	YES	NO
Diabetes	( )	( )
Thyroid Disorder	( )	( )
Prostate Disease	( )	( )
Chronic Headaches	( )	( )
Convulsions, Epilespsy, Seizures	( )	( )
Fainting/Dizziness	( )	( )
HIV/AIDS	( )	( )
Hormonal Condition	( )	( )
STD/Venereal Disease	( )	( )
Hepatitis (any type)	( )	( )
Anxiety/Depression	( )	( )
Visual Disturbances	( )	( )

Other Diseases or Conditions: _____

_____

_____

List all surgical procedures & dates: _____

_____

_____

_____

WOMEN:

Polycystic Ovarian Syndrome (PCOS or PCOD)	( )	( )
Tumors/Growths/Cysts	( )	( )

If YES, when: _____ and where: _____

Menstrual Irregularity	( )	( )
Are you pregnant?	( )	( )
Are you nursing?	( )	( )
Do you plan on becoming pregnant?	( )	( )

If YES, when? _____

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SKIN

Do you have redness/darkness from scars? ( ) YES ( ) NO
Have you ever had skin cancer? ( ) YES ( ) NO

If yes, what type? _____ When? _____

Do you wear sunscreen daily? _____ When outside/on vacation? _____ SPF# _____

When were you most recently in the sun? _____ Activity? _____ Duration of Exposure? _____

Do you have a history of any specific skin diseases? ( ) YES ( ) NO Which?_____
Do you have problems with healing? ( ) YES ( ) NO

Have you had any blistering sunburns? ( ) YES ( ) NO When? _____
Do you develop keloids (raised, bumpy scars)? ( ) YES ( ) NO
Do you bleed easily? ( ) YES ( ) NO
Do you smoke? ( ) YES ( ) NO

Do you have any tattoos or permanent makeup? ( ) YES ( ) NO Where? _____

Do you develop skin rashes in reaction to: ( ) Medications ( ) Food ( ) Topical Neosporin
( ) Environment ( ) Latex ( ) Bandages
( ) Anesthetics (Novocaine, xylocaine, lidocaine, etc.)

( ) Other Specify: _____

SKIN CONCERNS (Please Circle the Conditions that Apply to You):

Excessive/Unwanted Hair Acne Flushing/Blushing Rosacea Enlarged Pores Oily Skin
Fine Lines Broken Capillaries Age/Sun Spots Oily T-Zone Dry Skin Scarring
Black or Whiteheads Rough, Dull Tone & Texture Red Spots on Body Loose Skin on Face/Neck/Body

Other (Describe): _____

SKIN REGIMEN (Please Circle Which Products You Currently Use and Specify the Type/Brand):

* Cleanser: Foaming Liquid Gentle/Milk/Non-foaming Type/Brand: _____
Glycolic Grainy _____
Bar Acne-Specific

* Toner: Moisturizing Clarifying Type/Brand: _____
Acne-Specific _____

* Moisturizer: Oil Free Anti-aging Type/Brand: _____
Cream Glycolic _____

* Treatment Products: _____

* SPF# _____ Type/Brand: _____

* Any Prescription Products (such as Retin-A): ( ) Yes ( ) No Type/Brand: _____

* At-Home Peels or Microdermabrasion? ( ) Yes ( ) No Type/Brand: _____

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SKIN PROCEDURE HISTORY:

Have you undergone any of the following procedures:

Microdermabrasion	( ) YES	( ) NO	WHEN? _____
Chemical Peel	( ) YES	( ) NO	WHEN? _____
Laser Resurfacing	( ) YES	( ) NO	WHEN? _____
Laser Hair Removal	( ) YES	( ) NO	WHEN? _____
Botox ®	( ) YES	( ) NO	WHEN? _____
Injectable Filler (such as Collagen or Restylane ®)	( ) YES	( ) NO	WHEN? _____
Thermage	( ) YES	( ) NO	WHEN? _____
Fraxel	( ) YES	( ) NO	WHEN? _____
Sclerotherapy (vein injections)	( ) YES	( ) NO	WHEN? _____
IPL/Fotofacial ®/Photofacial	( ) YES	( ) NO	WHEN? _____
Facial	( ) YES	( ) NO	WHEN? _____
Waxing/Threading	( ) YES	( ) NO	WHEN? _____

Please disclose any minimally invasive cosmetic surgical procedures you have had:

What Type? _____ When? _____

Please disclose any cosmetic surgical procedures that required general anesthesia:

What Type? _____ When? _____

_____ _____/_____/_____

Patient Signature Date

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