Keller Dermatology, P.A.

Cosmetic Consultation Questionnaire

Patient Name _____ Date _____

Do you suffer from any of the following conditions? Please check all that apply

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Heart disease
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Epilepsy
- ☐ Herpes Infections/Cold Sores/Fever Blisters
- ☐ Eczema/Atopic Dermatitis
- ☐ Contact Dermatitis
- ☐ Sensitive Skin
- ☐ Rosacea
- ☐ Psoriasis

Do you: (please check all that apply)

- ☐ Smoke
- ☐ Drink Alcohol (how many/week _____)
- ☐ Get cold sores/fever blisters

Are you: (please check all that apply)

- ☐ Currently Pregnant
- ☐ Currently Breastfeeding

Which treatments interest you: (please check all that apply)

- ☐ Botox/Dysport
- ☐ Sclerotherapy for Spider Veins
- ☐ Chemical Peels
- ☐ Not Sure

What are your cosmetic concerns: (please check all that apply)

- ☐ Brown Spots
- ☐ Breakouts
- ☐ Skin Discoloration
- ☐ Skin Texture
- ☐ Fine Lines/Wrinkles
- ☐ Skin Care
- ☐ Other

Are you currently using any of the following products: (please check all that apply)

- ☐ Retin-A/Tretinoin
- ☐ Valtrex/Zovirax/Acyclovir/Famvir
- ☐ Coumadin/Warfarin
- ☐ Hormone Replacement
- ☐ Birth Control Pills
- ☐ Glycolic Acid/Alpha-hydroxy Acid
- ☐ Plavix
- ☐ Accutane (within the past 1 year)
- ☐ Aspirin
- ☐ Heparin
- ☐ Vitamins
- ☐ Antibiotics (which ones _____)
- ☐ Skin Lightening
- ☐ Acne Medications (which ones _____)

Please list all medications that you are currently taking (including over the counter medications such as aspirin, vitamins, health supplements, and medicated creams): _____

_____

_____

Please list all of your medication allergies: _____

_____

_____