

Charlottesville Dermatology

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HOW CAN WE HELP YOU WITH WHAT BOTHERS YOU MOST ABOUT YOUR SKIN?

Name: _____ Date of Birth: _____ Today's Date: _____

Email: _____ Phone # _____

I am bothered by: (please check all that apply)

- Unwanted hair growth on my face/body
- Redness of my face
- Fine lines & wrinkles on my face
- "Crow's feet"
- Thin lips
- Wrinkles around my mouth
- "Hollow" cheeks
- Red veins on my face
- Red spots on my face/body
- Deep lines on my cheeks/ "jowls"
- Dark spots on my face/chest/hands
- Acne scars
- Wrinkles around eyes
- Preventative Skin care
- Moles that I would like checked

Procedures or products of interest to you (please check all that apply)

- BOTOX & DYSPORT
- Dermal Fillers (i.e. Juvederm/Restylane. Radiesse)
- Facial Volumization (Sculptra)
- Clarisonic Skincare Brush
- Obagi
- IPL
- Fraxel
- Laser hair removal
- Microdermabrasion
- Chemical peel
- Laser vein removal
- Sclerotherapy

Treatment Goals: Instant Gradual (subtle change) Short-term Long-lasting

Are you pregnant trying to become pregnant or lactating? Yes No

Do you get cold sores or fever blisters? Yes No

Do you use a tanning bed? Yes No

Do you use sunless tanning lotions? Yes No

Do you use sunscreen? Yes No

Have you ever used a retinoid cream on your face? (Retin-A, Differin, etc.) _____

Have you ever had facial cosmetic surgery? _____

How did you hear about us?

My physician (full name) _____ Other: _____