



Name _____ SSN: _____ Today's Date ____/____/____
Last First Mo Day Yr

Address _____ Birth Date ____/____/____
Mo Day Yr

City _____ State _____ Zip _____

Best phone number to contact you regarding treatment and where we may leave a message:

Home Phone: () _____ Cell Phone: () _____ Work Phone () _____

E-Mail _____ How did you hear about us? _____

Primary Care Physician _____ Physician Phone Number _____

Please answer the following questions:

YES NO

Are you using any prescribed medications? If Yes, List: _____

Are you using any herbal medications? If Yes, List: _____

Do you take oral anti-coagulant (blood thinning) medication? _____

Are you allergic to any cosmetic ingredients, medications, or foods? If Yes, List:

Are you pregnant or trying to become pregnant? _____

Do you smoke? How much? _____ For how long? _____

Do you spend a lot of time outdoors or use a tanning bed often? _____

Do you have tattoos or permanent makeup? _____

Please tell us your main concern that brought you to our office today? _____

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

Sun Damage
Uneven skin tone
Enlarged Pores
Acne

Visible Blood Vessels
Clogged Pores
Excessive Oiliness
Wrinkles

Brown Spots
Unwanted Hair

Upper lip lines
Sun Spots

Pimples
Scarring

What is your skin type? Dry Normal Oily Combination

How much water do you consume per day? _____

Please check the product and list the BRAND NAME of items you currently use:

Cleanser _____ Soap _____ Glycolic Wash _____
Moisturizer _____ Night Cream _____ Salicylic Wash _____
Eye Cream _____ Sunscreen _____ Alpha Hydroxy Cream _____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging, or hyperpigmentation? YES NO If yes, please list:

Have you ever had any of the following wrinkle fillers or implants? YES NO

Collagen Restylane Perlane Hylaform Silicone Radiance Sculptra

If so, when was it done? _____ What area? _____ By whom? _____

Please check any health problems, past or present:

Seizures Skin Cancer Hepatitis
Hormonal problems Cystic Acne Asthma
High Blood Pressure Autoimmune (Lupus, Scleroderma) NONE
Diabetes Thyroid
Heart Problems Cancer Other: _____

Do you have any of the following chronic skin disorders? YES NO

Psoriasis Dermatitis Eczema Keloid Scarring
Fever Blisters Cold Sores Sun Blisters Herpes Simplex/Blisters

Have you ever undergone any of the following treatments? YES NO

Microdermabrasion Acid Peel Cosmetic Surgery Lasers Botox Accutane

When and where was it done? _____

Are you currently removing hair by any of the following methods? YES NO

Waxing Tweezing "Nair" type products Electrolysis Laser Hair Removal

If so when was it done _____ what area _____ what type of laser _____

I certify that the above information is correct to the best of my knowledge. _____

Patient's Signature

WGLC Notes:

