PANZER DERMATOLOGY AND COSMETIC SURGERY

PRE-TREATMENT EVALUATION FORM

Date: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Medical History: _____

Current Medications: _____

Drug Allergies: _____

Contact/Food Allergies: _____

Dates of any surgeries including cosmetic: _____

Pregnant or planning to be pregnant: _____

Do you smoke? Yes_____ No_____ How many _____
Do you drink? Yes_____ No_____ How much _____

Facial medications: _____

Any previous peels/laser treatments? Yes_____ No_____
Do you wax or use hair removal creams? Yes_____ No_____
Have you ever taken Accutane? Yes_____ No_____
Any history of Herpes, Hives, Cold Sores, Fever Blisters? Yes_____ No_____
Any history of Keloids (abnormal scaring)? Yes_____ No_____
Do you suntan? Yes_____ No_____
Do you use sunscreen everyday? Yes_____ No_____ (If Yes) What SPF are you using?_____

What is your current skin care regimen including cleansers, toners, moisturizers, scrubs, facial masks, etc.
_____
_____

SKIN TYPE:
Dry _____ Oily _____ Sensitive _____ Rough _____ Combination _____ Normal _____

What areas would you like to improve upon? _____