



Lexington Plastic Surgery

Facial Consult Sheet

Date: _____

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Does your job require that you work outdoors? NO YES

What would you like to achieve from your treatment today? _____

SKIN CARE QUESTIONNAIRE

Have you ever had a facial treatment before? NO YES, when? _____

Which of the following best describes your skin type? **(Please circle one)**

- | | | |
|-----|------------------------|----------------------------------|
| I | Creamy Complexion | Always burns easily, never tans |
| II | Light Complexion | Always burns, tans slightly |
| III | Light/Matte Complexion | Burns moderately, tans gradually |
| IV | Matte Complexion | Seldom burns, always tans well |
| V | Brown Complexion | Rarely burns, deep tan |
| VI | Black Complexion | Never burns, deeply pigmented |

Do you have any special skin problems or concerns pertaining to your face or body? NO YES

Specify: _____

Have you ever had chemical peels, laser or microdermabrasion? NO YES

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A products? NO YES

Specify: _____



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What skin care products are you currently using? **(List brand where known)**

Soap _____ Shower Gels _____

Toner _____ Body Lotions _____

Mask _____ Sunscreen _____

Eye Product _____ SPF _____

Cleanser _____ Night Moisturizer/Cream _____

Daily Moisturizer _____ Other _____

Exfoliate _____ Scrubs _____

Makeup Products _____

Have you used an acne medication? NO YES, when? _____ Which drug? _____

Have you recently used any self-tanning lotions, creams or treatments? NO YES, specify: _____

Have you used any of the following hair removal methods in the past six weeks? NO YES

(Circle all that apply):

Shaving Waxing Electrolysis Plucking Tweezing Stringing

What areas of concern do you have regarding your skin: **(Please check any that apply and explain?)**

- | | | | |
|-----------------------|-----------------------|---------------------|-----------------------|
| Breakouts/Acne | <input type="radio"/> | Uneven skin tone | <input type="radio"/> |
| Blackheads/Whiteheads | <input type="radio"/> | Sun Damage | <input type="radio"/> |
| Excessive oil/shine | <input type="radio"/> | Wrinkles/fine lines | <input type="radio"/> |
| Rosacea | <input type="radio"/> | Dull/dry skin | <input type="radio"/> |
| Broken capillaries | <input type="radio"/> | Flaky skin | <input type="radio"/> |
| Redness/ruddiness | <input type="radio"/> | Dehydrated | <input type="radio"/> |
| Sun spot/brown spot | <input type="radio"/> | Other _____ | |

EYES:

Dehydrated Wrinkles Puffiness Dark circles Other: _____

LIPS:

Dehydrated Cracked/Chapped lips Other: _____



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Have you ever had an allergic reaction to any of the following? **(Please check any that apply and explain)**

Cosmetics	<input type="radio"/>	AHA' s	<input type="radio"/>
Medicine	<input type="radio"/>	Fragrance	<input type="radio"/>
Food	<input type="radio"/>	Shellfish	<input type="radio"/>
Animals	<input type="radio"/>	Latex	<input type="radio"/>
Sunscreens	<input type="radio"/>	Drugs	<input type="radio"/>
Iodine	<input type="radio"/>	Pollen	<input type="radio"/>
		Other _____	

Have you had any recent tanning bed or sun exposure that changed the color of your skin? NO YES

Specify: _____

Have you experienced BOTOX ®, Restylane, Juvederm or Collagen injections? NO YES

Specify: _____

FEMALE CLIENTS ONLY

Are you taking oral contraceptives? NO YES

Specify: _____

Are you pregnant or trying to become pregnant? NO YES

Are you lactating? NO YES

Are you having any menopause problems? NO YES

Specify: _____

Are you undergoing any hormone replacement therapy? NO YES

Specify: _____



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MALE CLIENTS ONLY

What is your current shaving system? Wet Shave Electric

Do you experience irritation from shaving? NO YES Ingrown hairs? NO YES

Please use this space to complete answers where space was insufficient.

Future Appointment/Contact:

May I contact you at your home or cell phone numbers to confirm future appointments?

NO YES

May I contact you via email/mail about future promotions and news? NO YES

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____