Jeff Alexander, MD.
Ashley Biggs, PA-C
Dermatology Clinic / Medical & Wellness Spa

Please print.

Name: _____ DOB: _____ Date: _____

Today's Skin Concerns: _____

Current Medications: _____

_____

Medication Allergies: _____

Please check for "yes".

Do you have allergies to the following? ☐ Tape ☐ Band-Aids ☐ Latex

Do you take any of the following? ☐ Aspirin ☐ Blood Thinners ☐ Steroids

Do you take antibiotics before surgery or dental work? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Please check if you have any of the following.

☐ Artificial heart valve ☐ Bleeding ☐ Phlebitis ☐ Heart disease

☐ HIV/AIDS ☐ Bleeding disorder ☐ Diabetes

☐ Have you or a family member had skin cancer/melanoma? (Please provide details below.)

_____

Please check any cosmetic concerns that apply to you.

- ☐ Acne scarring
- ☐ Deep wrinkles
- ☐ Skin laxity
- ☐ Short or inadequate eyelashes
- ☐ Oily skin
- ☐ Safe sunless tanning
- ☐ Lower back pain
- ☐ Sore feet
- ☐ Love handles, muffin tops, spare tire
- ☐ Acne prone skin
- ☐ Fine lines
- ☐ Loss of facial volume
- ☐ Brown spots and dark or red pigment
- ☐ Dull skin tone
- ☐ Unsightly veins
- ☐ Sore muscles/back pain
- ☐ Fatigue

Other: _____

Are you currently a client of the Skin Care Institute? ☐ Yes ☐ No