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Cosmetic and Mohs Patients

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

COSMETIC AND LASER PATIENTS ONLY

Please describe the reason for today's cosmetic / laser consultation:

_____

_____

Please indicate if you would like to discuss any of the following. (Mark all that apply.)

Botox ® / Dysport ® ◯ fillers ◯ spider vein treatment ◯ chemical peels ◯
skincare ◯ laser hair removal ◯ removing unattractive growths ◯ laser procedures ◯
general information about non-surgical cosmetic procedures ◯ other ◯

Have you ever had Botox ® treatment?	yes ◯	no ◯
Have you ever had Dysport ® treatment?	yes ◯	no ◯
Have you had any cosmetic surgical procedure(s)?	yes ◯	no ◯
Have you had any laser procedure(s) in the past?	yes ◯	no ◯
Have you ever had filler treatment?	yes ◯	no ◯
Have you ever had chemical peels?	yes ◯	no ◯

If you have had any treatment in the past, please specify below:

TYPE OF TREATMENT	WHEN (year)	WAS IT EFFECTIVE?	ADVERSE EFFECTS?

If you are interested in laser hair removal, what form of hair removal have you used in the past? (Mark all that apply.)

waxing ◯ tweezing ◯ electrolysis ◯ shaving ◯ laser ◯

Do you exercise regularly?	yes ◯	no ◯

What skin care products do you use?

_____

_____

SAMPLE

Mohs / Surgery PATIENTS ONLY

How long has the problem been present?

0-3 months ◯ 4-6 months ◯ 7-12 months ◯ >1 year ◯

Was a biopsy done?	yes ◯	no ◯
Was there any previous treatment?	yes ◯	no ◯

If yes, type:

surgery ◯ Mohs ◯
Ed &C (scrape and burn) ◯ radiation therapy ◯ liquid nitrogen (freezing) ◯

Please mark all that apply for today's problem.

Have you noticed a change in any of the following?

size ◯ elevation ◯ other ◯ none ◯

Have you had any of the following associated symptoms?

bleeding ◯ infection ◯ tingling ◯ itching ◯
pain ◯ ulceration ◯ other ◯ none ◯

How would you describe the severity of your symptoms?

no symptoms ◯ occasional symptoms ◯ constant symptoms ◯

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