MATTHEW SCHULMAN M.D.
BOARD CERTIFIED PLASTIC SURGEON

Medical Skincare Assessment

Name: _____ **Date:** _____

Date of Birth: _____ **Email:** _____

Home Address: _____

Phone #: _____ **How did you hear about us?** _____

Have you ever seen a physician or technician specifically for a skin problem or skin care? Yes No

If yes, when and for what reason? _____

*Do you have any allergies or skin sensitivities? Yes No

If yes, list ALL allergies/skin sensitivities_____

Do you currently take any oral medications? Yes No

If yes, list all oral medications (Accutane, oral hormones, birth control pills, antibiotics, diuretics etc…)

_____

*Do you use any topical medications? Yes No

If yes, list all topical medications (Retin-A, Hydroquinone, Benzoyl Peroxide, Metrogel, Cortisone etc…)

_____

Have you ever taken Accutane (Isotretinoin- oral drug used to treat severe nodular acne) Yes No

___I currently take Accutane ___I took Accutane in the past Date discontinued_____

Do you currently use any skin care products as a daily regimen? Yes No

If yes, list the products you use _____

*Have you done any aggressive exfoliation, waxing or Laser Hair Removal on your skin in the last two weeks? Yes No

If yes, explain what type _____

Have you previously had any of these skin procedures? Yes No If no, skip this section

Microdermabrasion/Dermaplaning Yes No Date of last treatment _____

Chemical Peel Yes No Type of peel/Date_____

Laser Resurfacing/Microneedling Yes No Type of procedure/Date_____

Facial Surgery Yes No Type of facial surgery/Date_____

Other skin procedure/date _____

Do you have a history of acne or breakouts? Yes No

Does your skin ever flake or feel dry and tight? Yes No

Is your skin ever shiny or oily a few hours after cleansing? Yes No

Have you ever been diagnosed with rosacea? Yes No

Are you in the sun frequently? Yes No

In the past, have you neglected to wear sun protection when outdoors? Yes No

*Do you currently wear sun protection everyday? Yes No

Are you willing to wear sun protection everyday? Yes No

Are you pregnant or trying to become pregnant? Yes No N/A

Have you ever had a cold sore? Yes No If yes, when was your last cold sore? _____

Fitzpatrick Scale (how your skin reacts to sun exposure)?

I Burn **II** Usually Burn **III** Sometimes Burn **IV** Rarely Burn **V** Never Burn, Brown **VI** Never Burn, Black

What specific areas do you want to treat? Face Neck Chest Back Hands Other_____

How do you want to improve your skin?

_____

_____

FINANCIAL AGREEMENT, CANCELLATION POLICY and CHARGE DISPUTE

We have designed specific protocols to help achieve the best results. Please note that in order to achieve these results, it is very important to adhere to the recommended treatment protocol. Failure to keep scheduled appointments may result in a less than satisfactory treatment result.

I agree that I am responsible for all charges incurred at this office (you will be made aware of any charges prior to receiving any treatment). I acknowledge that your cancellation policy requires 24 hours notice for any appointment cancellations or rescheduling of my visits after my initial consultation. If I do not give adequate notice a charge will be made to my credit card that is on file: $150.00 for Reaction appointments, and $75.00 for other aesthetician services. This charge is considered valid and authorized without a signed charge slip. If a valid credit card is not on file, I will be billed, and will pay this bill. All outstanding balances must be paid prior to be given another appointment. No refund will be made for any package if patient decides to discontinue treatment. Balance will remain on patient's account and can be used within a one-year period. I agree that any dispute regarding any charges will be addressed with Dr. Schulman's Office directly and not my bank or credit card company. This specifically means that I will not attempt to resolve my dispute by reversing any credit card charges or canceling any checks.

I am aware of the above policies and am in agreement. I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Patient Name (print): _____

Patient Signature: _____ Date_____