Graper • Harper
Cosmetic Surgery

Garrett Harper, MD • **Evon Zoog**, MD

Skin Care

Name of Patient: _____

Skin Concerns

- ☐ Acne
- ☐ Acne scars
- ☐ Lesions/Growths
- ☐ Age spots
- ☐ Birthmarks
- ☐ Eczema
- ☐ Freckles
- ☐ Hair Removal
- ☐ Brown spots
- ☐ Large pores
- ☐ Laxity
- ☐ Photoaging
- ☐ Port wine stains
- ☐ Psoriasis
- ☐ Wrinkles
- ☐ Scar
- ☐ Skin texture
- ☐ Uneven skin tone
- ☐ Vascular lesions/Red spots

Skin Concerns Duration

Time

☐ 1 ☐ 4 ☐ 7 ☐ 10 ☐ > 12
☐ 2 ☐ 5 ☐ 8 ☐ 11
☐ 3 ☐ 6 ☐ 9 ☐ 12

Unit

☐ Day ☐ Week ☐ Year ☐ Patient unsure
☐ Days ☐ Weeks ☐ Years

Areas I would like to improve are:

- ☐ Forehead
- ☐ Browline
- ☐ Around eyes
- ☐ Cheeks
- ☐ Around the mouth
- ☐ Lips
- ☐ Chin
- ☐ Neck
- ☐ Underarms
- ☐ Arms
- ☐ Hands
- ☐ Chest
- ☐ Back

Current Skin Care (AM/PM) Routine

	AM Routine	PM Routine
Cleanser	_____	_____
Toner	_____	_____
Antioxidant	_____	_____
Bleach	_____	_____
Retinoid	_____	_____
Moisturizers	_____	_____
Eye Creams	_____	_____
Sunscreens	_____	_____
Notes	_____	_____

2915 Coltsgate Road • Suite 103 • Charlotte, NC 28211
P 704.375.7111 • **F** 704.375.0444 • www.ghsurgery.com

Please list all medications (including aspirin, vitamins and over-the-counter medications) that you are presently taking. If none, write "none."

Name of medication	Reason for medication

Please list allergies, if none, please write "none."

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

What is your ethnic background?

☐ Caucasian ☐ Asian ☐ Native American ☐ Eastern Mediterranean
☐ African-American ☐ Hispanic ☐ Arab ☐ Many

HIV Cert

☐ I certify that I am not HIV positive, have AIDS or Hepatitis C.

Is your skin?

☐ Dry ☐ Oily ☐ Combination ☐ Acne prone

Have you ever had a skin allergy?

☐ Yes ☐ No

Do you have a history of acne or periodic breakouts?

☐ Yes ☐ No

Have you ever had an adverse reaction after using a skin care regimen?

☐ Yes ☐ No

Physical History

	Yes	No	Details
Do you wax or use depilatories on your face?	☐	☐	_____
Do you have a history of cold sores?	☐	☐	_____
Have you had any active lesions in the last 4-6 weeks?	☐	☐	_____
Have you had chemotherapy or radiation?	☐	☐	_____
Have you had facial surgery, facial peels, laser surgery, Microdermabrasion, recent Botox, Restylane or Juvederm?	☐	☐	_____
Have you or any member of your family had skin cancer?	☐	☐	_____
Are you active outdoors?	☐	☐	_____
In the past, have you negeclted to use sunscreen when outdoors?	☐	☐	_____
Do you use DAILY sun protection?	☐	☐	_____
Do you wear contacts?	☐	☐	_____
Is your skin fragile or bruise easily?	☐	☐	_____
Do you form thick or raised scars?	☐	☐	_____
Have you ever seen a Dermatologist?	☐	☐	_____
Do you take vitamins or food supplements?	☐	☐	_____
Do you have a history of chronic acne?	☐	☐	_____
Do you have a history of skin sensitivity?	☐	☐	_____
HAVE YOU EVER TAKEN ACCUTANE?	☐	☐	_____
Do you smoke?	☐	☐	_____
Do you consume alcohol?	☐	☐	_____
<u>FOR WOMEN ONLY</u>			
Are you pregnant?	☐	☐	_____
Are you going through menopause?	☐	☐	_____
During pregnancy, did you get hyperpigmentation or masking?	☐	☐	_____

Check any topic medications (Rx or OTC) you use or have used:

☐ Acne	☐ Glycolic Acid	☐ Differin
☐ Retin-A/Renova	☐ Tazorac	☐ Other _____

Are you currently taking or have you ever used:

☐ Tranquilizers	☐ Birth Control/Hormones	☐ Allergy Medications
☐ Antibiotics	☐ Antidepressants	☐ Coumadin
☐ Diuretics	☐ Steroids	☐ Aspirin