KNIGHT
DERMATOLOGY INSTITUTE
The Center for Cosmetic & Laser Skin Surgery
(407) 992-0660
www.knightdermatology.com

So that we may better serve you, please answer the following questions:

Name: _____**Date of Birth**: _____**Today's Date**: _____

When looking at my face in the mirror, I believe I look:

Younger than my true age		My true age		Older than my true age
1	2	3	4	5

I am bothered by:

Unwanted hair growth on my face/body	□ Yes	□ No
Redness of my face	□ Yes	□ No
Fine lines & wrinkles on my face	□ Yes	□ No
"Crow's feet"	□ Yes	□ No
Thin lips	□ Yes	□ No
Wrinkles around my mouth	□ Yes	□ No
"Hollow" cheeks	□ Yes	□ No
Red veins on my face	□ Yes	□ No
Red spots on my face/body	□ Yes	□ No
Deep lines on my cheeks/ "jowls"	□ Yes	□ No
Dark spots on my face/chest/hands	□ Yes	□ No
Blemishes/blackheads/whiteheads	□ Yes	□ No
Unwanted tattoo(s)	□ Yes	□ No
Acne scars	□ Yes	□ No

Do you have any allergies to oral or topical medications?
If so, please explain _____

Are you currently taking any prescribed or OTC (over the counter) medications?
If so, please list them_____
Are you pregnant or lactating?_____
Do you get cold sores or fever blisters? _____
Do you use a tanning bed?_____ Last usage_____
Do you use sunless tanning lotions? _____Last usage_____
Do you use sunscreen? _____How often?_____
Have you ever used a retinoid cream on your face? (Retin-A, Differin, etc.)_____
Have you ever had facial cosmetic surgery?_____
Do you have cheek or chin implants? _____

Procedures or products of interest to you (please check all that apply)

- ☐ BOTOX Cosmetic
- ☐ Dermal Fillers (i.e. EVOLENCE/Juvederm/Restylane)
- ☐ Fractional CO_2 Laser Resurfacing (Active FX)
- ☐ Facials
- ☐ Microdermabrasion
- ☐ OBAGI, RevaleSkin, Kinerase
- ☐ Tattoo Removal
- ☐ Clarisonic Skincare Brush
- ☐ Skin Care Programs
- ☐ Birthmark Removal
- ☐ Correction of Sun Damage/Age Spots
- ☐ Facial Volumization (Sculptra)
- ☐ Removing Facial Veins
- ☐ Hair Removal
- ☐ Chemical Peels
- ☐ Correction of Leg Veins

☐ Other, please specify _____

How did you hear about us?

- ☐ My physician (full name) _____
- ☐ A friend or family member (name) _____
- ☐ Internet

Cancellations within 24 hours of scheduled appointment are subject to a $100.00 cancellation fee.

Patient Signature _____ Date_____/_____/_____

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OFFICE USE:

*Hx:*_____
_____
_____
_____
_____

*Assessment:*_____
_____
_____

*Plan:*_____
_____
_____
_____
_____

KDI Authorized Signature: _____ *Date:* _____