



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

I am bothered by:

- Unwanted hair growth on my face/body
Redness of my face
Fine lines & wrinkles on my face
'Crow's feet'
Thin lips
Wrinkles around my mouth
'Hollow' cheeks
Red veins on my face
Red spots on my face/body
Deep lines on my cheeks/ 'jowls'
Dark spots on my face/chest/hands
Blemishes/blackheads/whiteheads
Unwanted tattoo(s)
Acne scars

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)

- | | |
|---|---|
| <input type="checkbox"/> BOTOX Cosmetic | <input type="checkbox"/> Skin Care Programs |
| <input type="checkbox"/> Dermal Fillers (i.e. EVOLENCE/Juvederm/Restylane) | <input type="checkbox"/> Birthmark Removal |
| <input type="checkbox"/> Fractional CO ₂ Laser Resurfacing (Active FX) | <input type="checkbox"/> Correction of Sun Damage/Age Spots |
| <input type="checkbox"/> Facials | <input type="checkbox"/> Facial Volumization (Sculptra) |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Removing Facial Veins |
| <input type="checkbox"/> OBAGI, RevaleSkin, Kinerase | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Clarisonic Skincare Brush | <input type="checkbox"/> 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** ____/____/____

OFFICE USE:

Hx: _____

Assessment: _____

Plan: _____

KDI Authorized Signature: _____ *Date:* _____