

Dr. Laura L. Bennett

**IMAGE SCULPTORS
CONSULTATION FORM**

Name: _____

Date: _____

1. Please circle one of the following skin types: Oily Dry Combination Not sure
2. Current skin care regimen: _____
3. Problems you want to improve: _____
4. Have you ever been treated for this problem before? Yes No
5. Circle issues you would like addressed:
Sun Spots/Age Spots Flushing of the skin Hair Removal
Wrinkles Large Pores Permanent Makeup
Have you noticed skin worsening? _____
If yes, when? _____
6. Are you interested in an Aggressive or Relaxing treatment?
7. If Aggressive; how much down time is acceptable?
8. Are you comfortable with extractions if necessary? Yes No
9. Do you have a history of any of the following **Please Circle**:
Accutane/Retin A use Heart disease Osteoporosis
Herpes/cold sores Blood clots Joint Swelling
Skin cancer or suspicious moles Easy bruising Epilepsy/Seizures
Dark spots after pregnancy High Blood Pressure Chemotherapy/Radiation
Tattoos/Permanent makeup Diabetes Cancer Where: _____
Keloids/Hypertrophic scarring Bleeding Disorders Arthritis Where: _____
Skin injury Varicose Veins Joint swelling: _____
10. Do you take any of these medications? Circle all that apply
Aspirin/ Ibuprophen Anti-coagulates (blood thinners)
Hormones/contraceptives Appetite suppressants (diet pills)
Thyroid medication Insulin
Sedatives Tranquilizers
Cortisone/Steroids Accutane
11. Please list any medications: _____
12. Are you taking any herbal preparations? (Ex. St. Jon's Wort) Yes No
If yes, please list: _____
13. Do you have any Allergies (food, medication ect.) _____
14. Do you wear contact lenses? Yes No
15. Have you had cold sores or fever blisters? Yes No
If yes, how often? _____
16. When was the last time you were exposed to the sun or a tanning bed? _____
17. Do you use chemical sun tan lotions? Yes No
If yes, please list: _____

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18. Are you planning a vacation in the sun? Yes No

19. Have you ever had skin resurfacing, rejuvenation or chemical peels? Yes No
If yes, when was your last treatment and what type of treatment did
have?_____

20. Have you ever had treatments for pigmented lesions? Yes No

21. Are you interested in learning about the skin care products we offer? Yes No

22. Are you interested in learning more about our services, including
Fillers, Botox, Chemical, Peels or Laser Hair Removal? Yes No

23. Are you interested in learning about surgical procedures you may be considering?

Breast Augmentation	Abdominoplasty
Breast Reduction	Facelift
Mommy Makeover	Liposuction

24. Please explain any additional information you think we may need to know:

25. Recommendation:

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