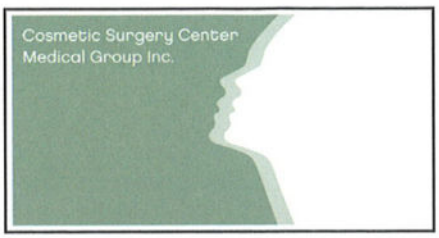

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BASIC INFORMATION

Name	Date of Birth	Age	Date Today
	/ /		/ /

Mailing Address	City	State	Zip Code

Primary Phone		Alternate Phone	
( )	☐ Cell ☐ Home ☐ Work	( )	☐ Cell ☐ Home ☐ Work

E-mail Address

Preferred Reminder Notification (please check one only)

☐ E-Mail ☐ Cell ☐ Home ☐ Work

Ask about text message reminders too!

We highly recommend joining our e-mail list. We provide easy appointment reminders. Also, exclusive specials, promotions, and birthday bonuses are ***only*** offered via e-mail. Don't miss out! We respect your privacy and will guard your e-mail. You may also opt out at any time.

Please Select Your Preferred Level of Contact (check all that apply)

☐ Monthly Newsletter (news, specials, new treatments, event invitations) ***Frequency: 1x per month plus 1 event reminder***

☐ Last Minute Promotions (Ask for details!) ☐ Birthday Bonus (for a special gift on your birthday!)

Employer | Occupation

Emergency Contact Name: Phone: ( )

Reason for your consultation:

Would you like information about treatment for any of the following? (circle all that apply):

Acne Wrinkles Sun Damage Nail Fungus Tattoo Removal Excessive Sweat Unwanted Hair

Age Spots Redness (Rosacea) Spider Veins Pigment Problems Teeth Whitening Shape/Size of Nose

Thin Lips Eye bags/Excess Skin Face/Neck Laxity Jowls Stretch Marks "Weak" Chin/"Flat" Cheeks

How did you hear about us? (please circle and include name or additional info where appropriate)

Friend or Family _____ Santa Barbara Independent Phonebook Other Publication _____

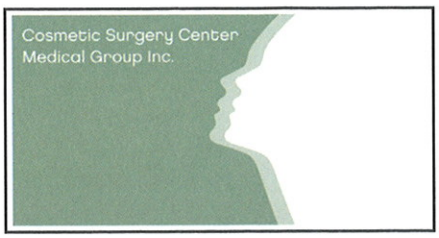
Business _____ Internet Walk-In Other _____

Authorization for Examination and Treatment

I, _____, represent to Dr. Perkins and staff that I am at least 18 years old, am accompanied by a legal guardian, or have an appropriate consent form that is signed by a legal guardian. I hereby authorize the clinical staff at the Cosmetic Surgery Center and/or Evolutions Medical Spa to take my medical history and perform any necessary examinations.

I also understand that photography is a necessary part of planning and evaluating treatment decisions. I therefore authorize the taking of photographs at the direction of Dr. Perkins or the clinical staff and under the conditions approved by them. The photographs will be used solely for documentation purposes and will be confidential unless otherwise disclosed and agreed upon. Finally, I agree to be financially responsible for any charges incurred at the Cosmetic Surgery Center and/or Evolutions Medical Spa.

Signature _____ **Date** _____



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MEDICAL HISTORY

Name (Please Print) _____ Date of Birth: _____

It is extremely important that we are aware of all of your medical conditions and of the medications and supplements/vitamins that you take. It will allow us to give you the best care that we can, and it can help us avoid any potential adverse interactions between your condition(s)/medication(s) and any treatments we may recommend. Please provide all of the following information and be as complete as possible.

Please list all medications you take or have taken in the past six months (including hormone therapy/birth control, photosensitizing drugs, aspirin, weight loss medication, Coumadin or any blood thinning medication, steroids, prescription eye drops, ibuprofen, etc) Use back of page if necessary:

Medications:	Amount	Frequency

List all ALLERGIES including LATEX: _____

Do you have a pacemaker or internal defibrilator? Yes No

Could you possibly be pregnant at this time? Yes No Are you lactating? Yes No

Have you ever taken Accutane? Yes No If yes, when and for how long? _____

Have you ever had cold sores? Yes No If yes, when was last outbreak? _____

Do you have a history of developing keloids? Yes No Do you bruise easily? Yes No

Are you a vegetarian or do you practice any special kind of diet? Yes No If yes, explain _____

Do you have a history of atypical moles, melanoma or skin cancer in yourself or family? Yes No

Have you or anyone in your family had an adverse reaction to topical anesthetics? Yes No

Have you or anyone in your family had an adverse reaction to local (injected) anesthesia? Yes No

Do you smoke? Yes No If yes, how much? _____

Do you drink? Yes No If yes, how much? _____

Please circle all of the following medical conditions you now have or have had in the past:

Bleeding tendency / diabetes / blood transfusions / blood clots / glaucoma / dry eyes / lung disease / TB / asthma wheezing / emphysema / bronchitis / irregular heart beat / stroke / heart disease / high blood pressure / heart attack chest pain / epilepsy / heart burn / vitiligo (pigment loss in the skin) / intestinal ulcers or bleeding / scelorderma rheumatoid arthritis / lupus / depression / mental illness / drug or alcohol addiction / malignant hyperthermia porphyria / hepatitis B / hepatitis C / HIV / any other serious illness, condition, or injury / none of the above

Use back to give details of any circled items

Please list any surgeries (including cosmetic) you have had along with the date of the surgery:

I acknowledge that I have disclosed my entire medical history and the above is a complete and accurate representation of my medical and psychological history and current status:

Signature: _____ Date: _____

Cosmetic Surgery Center
Medical Group Inc.

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SKIN CARE QUESTIONNAIRE

Name (Please Print) _____ Date of Birth: _____ Today's Date: _____

Have you ever seen a dermatologist for your skin? Yes No If yes, regarding? _____

Are you currently using: (circle all that apply)

Retina A (tretinoin) Renova Glycolic acid Other alpha hydroxy product(s) Vitamin C product(s)

What other skin care products are you currently using?

Do you have pigment problems? Yes No If yes, explain _____

Have you ever had Botox or dermal filler injections? Yes No If yes, what and when? _____

Have you ever had laser or intense pulsed light treatments? Yes No If yes, when? _____

Hypersensitivity

Do you have or have you ever had a skin allergy? Yes No If yes, explain _____

Do you have photosensitivity? Yes No

Hormones (female clients only)

Do you have regular periods? Yes No

Are you going through menopause? Yes No

During pregnancy did you ever get hyperpigmentation or masking? Yes No N/A

Vascularity

Do you have broken capilleries? Yes No

If yes, where? Nose Area Cheek Area Chin Area Forehead Entire Face Other _____

Acne:

Do you have any history of acne or periodic breakouts? Yes No

Circle all that are applicable to you:

Pimples Whiteheads Blackheads Acne Scars Cysts Flakiness Enlarged Pores

Ability to Heal:

Does your skin seem fragile or heal slowly when injured? Yes No

Do you scar easily? Yes No Any chronic skin problems? Yes No If yes, explain: _____

Sun History

Do you (or in the past did you) spend a lot of time in the sun (for work and/or leisure time?) Yes No

If yes, roughly how many hours a week do you (did you) spend in the sun? _____

Do you use sunscreen daily? Yes No

Have you or any member of your family had skin cancer? Yes No If yes, where? _____

What bothers you most about your skin? _____

Do you consider your skin type to be: (circle all that apply)

Normal Combination Sensitive Rosacea Oily

Acne-prone Pigmented Dry Aged