

# Advanced DermaCare

## SKIN HISTORY AND EVALUATION *CONFIDENTIAL*

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_

OFFICE PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

BIRTH PLACE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

HOW IS THE BEST WAY TO CONTACT YOU?

• **HAVE YOU EVER SEEN A DERMATOLOGIST FOR YOUR SKIN?** YES NO

• **HAVE YOU EVERY USED ACUTANE?** YES NO

• **WHAT TOPICAL MEDICATIONS DO YOU USE OR HAVE USED?**

ACNE RETIN-A GLYCOLIC ACID OTHER\_\_\_\_\_

• **HAVE YOU EVER HAD A SKIN ALLERGY?** YES NO

**IF YES, RELATED TO:** FOOD ASPIRIN COSMETICS RASHES FABRICS

OTHER\_\_\_\_\_

• **DO YOU TAKE VITAMINS?** YES NO

\_\_\_\_\_MULTI-VITAMIN \_\_\_\_\_ANTIOXIDANT \_\_\_\_\_OTHER

• **HOW DO YOU TAN?** BURN USUALLY BURN BURN THEN TAN USUALLY TAN  
ALWAYS TAN

• **PIGMENTATION:** EVEN UNEVEN BIRTHMARK PREGNANCY MASK

• **HAVE YOU EVER EXPERIENCED HYPERPIGMENTATION?** YES NO

• **DO YOU HAVE REGULAR PERIODS?** YES NO

• **ARE YOU GOING THROUGH MENOPAUSE?** YES NO

• **DURING PREGNANCY, DID YOU EVER EXPERIENCE HYPERPIGMENTATION OR MASKING?**

YES NO

• **DO YOU FORM THICK OR RAISED SCARRING FROM A CUT OR BURN?** YES NO

• **DO YOU WAX OR USE DEPILATORIES ON YOUR FACE?** YES NO

• **DO YOU EVER GET COLD SORES?** YES NO

• **WHAT PERCENTAGE OF TIME DO YOU SPEND IN THE SUN?**

\_\_\_\_\_SUMMER \_\_\_\_\_WINTER

• **IN THE PAST (INCLUDING CHILDHOOD) DID YOU LIVE IN A SUNBELT AND SUNBATHE?**  
YES NO

• **IN THE PAST HAVE YOU NEGLECTED TO USE A SUNBLOCK WHEN OUTDOORS?** YES NO

• **HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER?** YES NO  
ANATOMICAL LOCATION \_\_\_\_\_

• **HOW DO YOU WANT TO IMPROVE YOUR SKIN?**

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• **WHAT SPECIFIC AREA DO YOU WANT TO TREAT?** FACE NECK CHEST BACK

• **DO YOU HAVE ANY METAL IMPLANTS IN YOUR BODY OTHER THAN DENTAL FILLINGS?**  
**(SUCH AS PACEMAKER, PINS IN BONES, OR A COPPER IUD)**

\_\_\_\_\_

• **HAVE YOU UNDERGONE PLASTIC SURGERY ON YOUR FACE? WHERE? WHEN?**

\_\_\_\_\_

• **PERSONAL PHYSICIAN NAME AND CITY**

\_\_\_\_\_

- **WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?**

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- **WHAT SPECIFIC SKIN PROBLEMS ARE YOU EXPERIENCING?**

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- **HAVE YOU EVER HAD A SKIN TREATMENT BEFORE?**

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- **DO YOU WEAR CONTACT LENSES?** \_\_\_\_\_

**CONSENT AND RELEASE**

I, \_\_\_\_\_ HAVE BEEN ADVISED AND FULLY INFORMED BY DIANE LOWERY OF ADVANCED DERMACARE CONCERNING THE NATURE OF THE TREATMENT PROCESS PROPOSED, TO BE ADMINISTERED BY THEM, HEREBY AUTHORIZE AND DIRECT THEM TO ADMINISTER SUCH PROCESS AND PERFORM SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE. MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT THAT (1) I HAVE READ, UNDERSTAND AND FULLY AGREE TO THE FOREGOING CONSENT, (2) THE PROPOSED TREATMENT PROCESS HAS BEEN SATISFACTORILY EXPLAINED TO ME, AND I HAVE ALL THE INFORMATION WHICH I DESIRE. (3) I HEREBY GIVE MY CONSENT AND AUTHORIZATION VOLUNTARILY AND RELEASE THIS ESTABLISHMENT AND ITS AGENTS OF ANY CLAIMS THAT I HAVE OR MAY HAVE IN THE FUTURE IN CONNECTION WITH THE DESCRIBED TREATMENT.

I UNDERSTAND THAT IF I FAIL TO GIVE 24 HOURS NOTICE TO CANCEL MY APPOINTMENT, I WILL BE CHARGED ONE HUNDRED DOLLARS (\$100.00).

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

**NOTICE**

PLEASE UNDERSTAND THAT IN ANSWERING QUESTIONS WE DO NOT DIAGNOSE NOR PRESCRIBE, BUT OFFER NUTRITION INFORMATION ONLY TO HELP YOU TO CO-OPERATE WITH YOUR DOCTOR IN YOUR MUTUAL GOAL OF BUILDING HEALTH. IN THE EVENT YOU USE THIS INFORMATION WITHOUT YOUR DOCTOR'S APPROVAL YOU ARE PRESCRIBING FOR YOURSELF WHICH IS YOUR CONSTITUTIONAL RIGHT, BUT WE ASSUME NO RESPONSIBILITY. DIANE D. LOWERY HAS A DOCTORATE IN NATUROPATHY AND A PH.D IN HOLISCTIC NUTRITION BUT IS NOT ARIZONA STATE LICENSED.

ADVANCED DERMACARE