



GRAPER  
COSMETIC  
SURGERY

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### SKIN CARE CONSULTATION

1. Have you ever seen a dermatologist for your skin?  Yes  No

2. Are you presently under a doctor's care?  Yes  No Why? \_\_\_\_\_

3. Are you currently taking or have you ever used:

<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Birth Control/Hormones	<input type="checkbox"/> Allergy Medications
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Coumadin
<input type="checkbox"/> Diuretics	<input type="checkbox"/> Steroids	<input type="checkbox"/> Aspirin

List ALL oral medications you are taking, including OTC drugs: \_\_\_\_\_  
\_\_\_\_\_

4. List any topical medications (prescription or over the counter) you use or have used:

<input type="checkbox"/> Acne	<input type="checkbox"/> Glycolic Acid	<input type="checkbox"/> Differin
<input type="checkbox"/> Retin-A/Renova	<input type="checkbox"/> Tazorac	<input type="checkbox"/> Other _____

5. Do you take vitamins or food supplements?  Yes  No List \_\_\_\_\_

6. Have you ever taken Accutane?  Yes  No When: \_\_\_\_\_ How long? \_\_\_\_\_

7. List ALL medications you are allergic to: \_\_\_\_\_

8. Have you ever had a skin allergy?  Yes  No

<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Other _____
<input type="checkbox"/> Fabrics	<input type="checkbox"/> Rashes	

Explain: \_\_\_\_\_

9. Do you have a history of chronic acne?  Yes  No Chronic skin sensitivity?  Yes  No

Explain: \_\_\_\_\_

10. Have you ever had an adverse reaction after using a skin care regimen?  Yes  No  
If yes, describe (rash, irritation, peeling, sensitivity, etc.) \_\_\_\_\_  
\_\_\_\_\_

11. **For women only:** Are you pregnant or lactating?  Yes  No

Do you have regular periods?  Yes  No Are you going through menopause?  Yes  No

During pregnancy, did you get hyperpigmentation or maskin?  Yes  No

12. Do you smoke?  Yes  No How much? \_\_\_\_\_

13. Do you consume alcohol?  Yes  No How much? \_\_\_\_\_

14. Do you have a history of acne or periodic breakout?  Yes  No

<input type="checkbox"/> Pimples	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Acne Scars
<input type="checkbox"/> Cysts	<input type="checkbox"/> Enlarged Pores	<input type="checkbox"/> Hormone Related
<input type="checkbox"/> Whiteheads		

Frequency: \_\_\_\_\_

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15. Is your skin?  Dry  Combination  Oily  Acne Prone
16. Does your skin appear fragile or burn easily?  Yes  No
17. Do you form a thick or raised scar from a cut or burn?  Yes  No
18. Do you wax or use depilatories on your face?  Yes  No Frequency: \_\_\_\_\_
19. Do you have a history of cold sores?  Yes  No Frequency: \_\_\_\_\_  
 Have you had any active lesions in the last 4-6 weeks?  Yes  No
20. Have you ever had chemotherapy or radiation?  Yes  No  
 Please explain: \_\_\_\_\_
21. **I certify that I am not HIV positive, have AIDS or Hepatitis C. (Initial Please)** \_\_\_\_\_
22. Have you had facial surgery, facial peels, laser surgery, Microdermabrasion, recent Botox or Restylane or Juvederm?  Yes  No When: \_\_\_\_\_
23. Have you or any member of your family had skin cancer?  Yes  No  
 Anatomical Location: \_\_\_\_\_
24. Are you active outdoors?  Yes  Explain: \_\_\_\_\_  
 In the past, have you neglected to use sunscreen when outdoors?  Yes  No
25. Do you use **daily** sun protection?  Yes  No SPF: \_\_\_\_\_
26. Do you or have you ever used tanning beds?  Yes  No Frequency: \_\_\_\_\_
27. What is your ethnic background? \_\_\_\_\_  
 During pregnancy, did you get hyperpigmentation or maskin?  Yes  No
- 28 Describe your daily skincare routine: A.M. \_\_\_\_\_  
 P.M. \_\_\_\_\_
29. Do you wear contact lenses?  Yes  No

I hope to achieve the following results (check all that apply):

<input type="checkbox"/> Diminish Fine Lines	<input type="checkbox"/> Shrink Enlarged Pores	<input type="checkbox"/> Reduce Scarring
<input type="checkbox"/> Control Acne	<input type="checkbox"/> Even Pigmentation	<input type="checkbox"/> Other _____
<input type="checkbox"/> Smooth Skin Texture		

The areas I would like most to improve are:

<input type="checkbox"/> Around the eyes	<input type="checkbox"/> Forehead	<input type="checkbox"/> Chest
<input type="checkbox"/> Cheeks	<input type="checkbox"/> Hands	<input type="checkbox"/> Arms
<input type="checkbox"/> Neck	<input type="checkbox"/> Chin	<input type="checkbox"/> Other _____
<input type="checkbox"/> Around the mouth	<input type="checkbox"/> Browline	

I hereby consent to allow \_\_\_\_\_ to perform services as deemed necessary for cosmetic improvement, including, but not limited to, Microdermabrasion, chemical exfoliation and topical cosmetic therapy.

Signature \_\_\_\_\_ Date \_\_\_\_\_