Randy Tate, M.D.
CENTRE FOR FACIAL PLASTIC SURGERY

Name: _____ Date:_____

Address:_____
(Street) (City) (State) (Zip)

Phone #: (Home)_____ Cell_____

Date of Birth_____ E-mail_____

Are you interested in receiving our cosmetic e-mails with specials and information? Yes ❑ No ❑

Occupation_____ Age:_____

Are you allergic to or ever had an allergic reaction to any products or ingredients? Yes ❑ No ❑

If yes, please list _____

Have you had a skin care or cosmetic procedure before? Yes ❑ No ❑

Do you currently suffer from any skin conditions?_____

Have you seen a dermatologist in the last five years? Yes ❑ No ❑

Are you currently taking any medications? Please list: _____

_____

Have you used any harsh exfoliants on your skin in the past 1-3 days prior to this visit? Yes ❑ No ❑

If so, please list: _____

Have you received any facial waxing services in the past 1-3 days prior to this visit? Yes ❑ No ❑

Are you interested in laser, Botox, fillers, or any surgical cosmetic procedures? Yes ❑ No ❑

Please list:_____

Health History:

❑ Auto – Immune Disorders	❑Take birth control	❑Mental Disease
❑ Cancer	❑Heart Disease	❑Neuro-muscular
❑ Cold Sores/ Fever Blisters	❑High Blood Pressure	❑Take Accutane
❑ Diabetes	❑Liver Disease	❑Skin Problems

Randy Tate, M.D.
CENTRE FOR FACIAL PLASTIC SURGERY

Currently:

Pregnant? Yes ❑ No ❑ Nursing? Yes ❑ No ❑
Smoke? Yes ❑ No ❑ How many per day? _____
Drink Alcohol? Yes ❑ No ❑ Amount per day?_____
Eat a lot of sugar? Yes ❑ No ❑
Consume caffeinated beverages? Yes ❑ No ❑
Indoor/Outdoor tan? Yes ❑ No ❑ How often?_____

Product History:

Cleanser	Yes ❑ No ❑	Type/Brand:
Toner/Astringent	Yes ❑ No ❑	
Moisturizer	Yes ❑ No ❑	
Sunscreen	Yes ❑ No ❑	
Treatments/Serums	Yes ❑ No ❑	
Eye cream	Yes ❑ No ❑	
Other	Yes ❑ No ❑	

How would you describe your skin? DRY ❑ NORMAL ❑ OILY ❑ ACNE PRONE ❑ SENSITIVE ❑

What bothers you most about your skin? _____

What would you like to achieve/gain from your visit today?_____

_____

The above information is true and accurate to the best of my knowledge. If in any case this information changes I will notify my practitioner. I understand that all known allergies should be described to the Esthetician and they are not held responsible for any adverse reactions to products during my service. I understand that the Esthetician is responsible for determining the best treatment method for my skin and therefore, if necessary my treatment can be terminated at any time. I understand that there is a 24 hour cancelation policy and that if I fail to give adequate notice I will be charged for the missed session.

_____ _____
Patient Signature Date

Submit