LAKESIDE
COSMETIC CENTER
CHELSEA OBOURN M.D.

Consultation Form

Please complete both sides of the form so we can provide you with the best care

Name:_____ **Date of Birth:**_____

Date:_____ **Patient ID:**_____

Who referred you to us? _____

Do you give us permission to send you information for coupons, events, special offers, and newsletters?

☐ **Email** ☐ **Mail** ☐ **Both**

Please provide E-Mail address: _____

Do you regularly apply Sun Protection? **YES** **NO**

Do you tend to have sensitive skin? **YES** **NO**

Are you prone to oily skin? **YES** **NO**

Are you prone to dry skin? **YES** **NO**

Are you pregnant? **YES** **NO**

Do you routinely see a Dermatologist? **YES** **NO** If yes, who? _____

Do you have or have you ever had any of the following?

Actinic Keratoses Basal Cell Cancer Melanoma Cancer Precancerous Moles Squamous Cell Cancer

If yes, please explain: _____

Do you have any skin conditions on your face or body such as psoriasis, eczema, or rosacea? **YES** **NO**

If yes, please specify: _____

Have you ever had chemical peels, microdermabrasion, microneedling, Botox, or facial fillers?

If yes, please indicate: _____

(Please Turn Over)

What skin care products are you currently using? (Please circle all that apply)

Soap Cleanser Exfoliator Toner Moisturizer Masque Eye Product Serums

Please list any prescription skin care products used: _____

_____

Do you ever experience the following? (Please circle)

Flakiness Tightness Obvious Dryness Hyperpigmentation Acne

Please circle any of the following that apply to you:

Broken Skin Fragile Capillaries Cold Sores Acne Scarring

Please circle if you are currently using of have used any of the following products within the last 12 months:

Accutane Retin-A Glycolic Acid Vitamin C Hydroquinone

What are your skin care goals? _____

_____

_____

_____

_____