Complete this form only if you have an appointment with our esthetician.

McKEOWN
cosmetic & reconstructive surgery
JOSEPH E. McKEOWN, MD FACS

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Are you pregnant or lactating: Yes ☐ No ☐ **(If so, treatments can start when you are finished lactating.)**

Do you wear contact lenses? Yes ☐ No ☐

Do you have permanent makeup? Yes ☐ No ☐ If so, what areas of the face? _____

Do you currently have a sunburn/windburn/red face? Yes ☐ Why? _____ No ☐

Are you in the habit of going to tanning booths? Yes ☐ No ☐ (If within the past three weeks, decline treatment)

Are you currently using Bioré® / nose strips? Yes ☐ No ☐

Are you currently using Retin-A® / Differin®? Yes ☐ No ☐ What strength? _____ For how long? _____

How frequently? _____ Where applied? _____ (Discontinue 5 days before and after treatment)

Are you currently using Accutane®? Yes ☐ No ☐ How long? _____

Those who are currently taking Accutane should be directed to their dispensing physician.

Are you currently using Tazorac® or Avage®? Yes ☐ No ☐ How long? _____ (Discontinue use 10 days before and after treatment) NOTE: Consult your physician before discontinuing use of any prescription.

Have you had a chemical peel or any type of procedure with a medical device? Yes ☐ No ☑ Within the last 14 days? Yes ☐ No ☐

Do you have regular collagen injections? Yes ☐ No ☐ (peels should precede injections by 14 days)

Do you have regular Restylane® injections? Yes ☐ No ☐ (peels should precede injections by 14 days)

Do you have regular Botox® injections? Yes ☐ No ☐ (peels should precede injections by 14 days)

What type of work do you do? _____ Airline travel? Yes ☐ How often? _____ No ☐

Do you participate in vigorous aerobic activity or sports? Yes ☐ No ☐ What type? _____

Have you recently had facial surgery? Yes ☐ No ☐ Describe: _____ How long ago? _____

Have you recently had laser resurfacing? Yes ☐ No ☐ When? _____ What kind? _____

Do you smoke? Yes ☐ No ☐ Average per day _____

Do you develop cold sores / fever blisters? Yes ☐ No ☐ Last breakout? _____

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7016 Lee Park Road | Mechanicsville, VA 23111 | (804) 730-7600 TEL
www.VirginiaCosmetic.com

Are you allergic / sensitive to (check all that apply): milk ☐ apples ☐ citrus ☐ grapes ☐ aloe vera ☐
aspirin ☐ perfumes ☐ latex ☐ hydroquinone ☐ mushrooms ☐ If any other allergies, please explain:

_____

Are you sensitive to alcohol-based products? Yes ☐ No ☐
Are you taking any medication at this time? Yes ☐ No ☐ (antibiotics may increase sensitivity) If yes, please list:

_____

Describe your skin: (check those that apply): Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Normal ☐ Dry ☐
T-Zone/Combination ☐ Oily ☐ Acne ☐ Comedones ☐ Milia ☐ Cysts ☐ Breakouts ☐ Acne-scarred ☐ Large pores ☐ Small pores ☐ Rosacea ☐ Eczema ☐ Freckled ☐ Sun-damaged ☐
Uneven/blotchy ☐ Mature ☐ Wrinkled ☐ Patchy dryness on _____ Melasma ☐
Hypopigmented ☐ Hyperpigmented ☐ Psoriasis ☐ Dehydrated (lacking moisture) ☐
Telangiectasia/broken surface capillaries ☐
Do you consider your skin SENSITIVE ☐ RESILIENT ☐ NOT SURE ☐ ? (Check)
Eye color: Blue ☐ Green ☐ Hazel ☐ Gray ☐ Lt. Brown ☐ Med. Brown ☐ Dk. Brown ☐
Natural hair color: Blond ☐ Red ☐ Lt. Brown ☐ Med. Brown ☐ Dk. Brown ☐ Black ☐
Gray/Silver ☐ White ☐
Skin tone: Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Lt. Olive ☐ Med. Olive ☐
Dark Olive ☐ Lt. Brown ☐ Med. Brown ☐ Dark Brown ☐ Soft Black ☐ Black ☐
What is your hereditary background? _____
Have you ever used any products that caused a bad reaction? Yes ☐ No ☐ If yes, please describe below:

_____

What are cosmetic improvements you would like to see in your skin? _____

_____

_____ _____

Patient / Client Signature Date

OFFICE USE ONLY

Patch test: Date _____ Solution _____ Test Area _____ Result _____

_____ _____

Technician Signature Date