

**PANZER DERMATOLOGY AND COSMETIC SURGERY**

**PRE-TREATMENT EVALUATION FORM**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Medical History: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Contact/Food Allergies: \_\_\_\_\_

Dates of any surgeries including cosmetic: \_\_\_\_\_

Pregnant or planning to be pregnant: \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ How many \_\_\_\_\_

Do you drink? Yes \_\_\_\_\_ No \_\_\_\_\_ How much \_\_\_\_\_

Facial medications: \_\_\_\_\_

Any previous peels/laser treatments? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you wax or use hair removal creams? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever taken Accutane? Yes \_\_\_\_\_ No \_\_\_\_\_

Any history of Herpes, Hives, Cold Sores, Fever Blisters? Yes \_\_\_\_\_ No \_\_\_\_\_

Any history of Keloids (abnormal scarring)? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you suntan? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use sunscreen everyday? Yes \_\_\_\_\_ No \_\_\_\_\_ (If Yes) What SPF are you using? \_\_\_\_\_

What is your current skin care regimen including cleansers, toners, moisturizers, scrubs, facial masks, etc.

\_\_\_\_\_  
\_\_\_\_\_

**SKIN TYPE:**

Dry \_\_\_\_\_ Oily \_\_\_\_\_ Sensitive \_\_\_\_\_ Rough \_\_\_\_\_ Combination \_\_\_\_\_ Normal \_\_\_\_\_

What areas would you like to improve upon? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
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