THE Hammett CLINIC
NEUROLOGY • WELLNESS

Skinology
Skin. Science. Simplified.

COSMETIC/ESTHETIC CONFIDENTIAL CONSULTATION FORM

First Name: _____Last Name:_____ DOB:_____
Address:_____
Phone: (H):_____ (W):_____ (C):_____
Email:_____ Referred By:_____

What is your hereditary background?

	African American		African		Australian		Eastern European		Hispanic/Latin American
	Indian		Mediterranean		Middle Eastern		Native American		Nordic/Scandinavian
	Pacific Islands		South American		South Asian		Western Europe		Other: _____

Natural Eye Color: _____ Natural Hair Color:_____

CHECK ALL TERMS YOU BELIEVE RELATE TO YOUR SKIN:

	Acne		Age Spots		Blackheads		Blistered		Blotchy		Breakouts
	Blotchy		Breakouts		Cancer		Cherry Angiomas		Cold Sores		Combination
	Cysts		Damaged		Dehydrated		Dermatitis		Dry		Eczema
	Even Tone		Fever Blisters		Firm		Freckles		Hairy		Herpes
	Hyperpigmentation		Hypertrophic Scars		Inflamed		Ingrown Hairs		Keloids		Keratosis
	Large Pores		Melasma		Milia		Moles		Oily		Open Lesions
	Peeling		Psoriasis		Puffy		Raised Growths		Red		Rosacea
	Sagging		Sallow		Scars		Sebaceous Hyperplasia		Sensitive		Skin Tags
	Sun Damage		Thin		Under Eye		Uneven		Warts		Wrinkles

What changes would you most like to see from the treatment(s) requested: _____
_____

WHAT OTHER AREAS OF INTEREST DO YOU HAVE? (Check all that apply)

	Acne Management		Body Contouring		Body Detoxification		Botox		Cellulite Reduction
	Chemical Peels		Dermal Fillers		Dermaplaning		Even Skin Tone		Fat Reduction Treatments
	Hand Rejuvenation		HIFU		Improve Skin Health		Intimate Brightening		Laser Treatments

	Lash/Brow Enhancement		LED Light Therapy		Lifting/Firming Treatments		Makeup		Microblading
	Microcurrent		Microdermabrasion		Microneedling		Migraines		Oncology Skin Care
	Permanent Hair Removal		Permanent Makeup		Product Knowledge		Tattoo Removal		Vajacial

Does your job require that you work outdoors? □ Yes □ No
On average how many hours each day do you spend outdoors? _____
Have you used a tanning booth within the last 30 days? □ Yes □ No If yes, when was the last visit?_____
Please check all prior facial treatment(s) you have received:

□ Chemical Peel □ Injections/Fillers □ Microcurrent
□ Cosmetic Surgery □ Laser Hair Removal □ Microdermabrasion
□ Body Wrap □ Laser Skin Resurfacing/IPL □ Microneedling
□ Dermaplaning □ Lash/Brow Extension □ Permanent Makeup/Tattoo
□ Electrolysis □ Lash Lift/Tint □ Spider/Broken Vein Treatment
□ Facial □ LED Therapy □ Surgical Threads

Any of these services in the last 6 months? □ Yes □ No
If yes, which and when:_____
Have you used Tretinoin, Retin-A, Renova, Differin, Tazorac, Avage, EpiDuo, Ziana, Adapalene Hydroxyl, or any products containing Retinol or a Vitamin-A derivative (common identified as an "anti-aging" skin product) in the last 30 days? □ Yes □ No
If yes, which product(s) and when did you last use each?

_____

_____

When did you last receive Botox or other similar injection? _____
Do you wear contacts? □ Yes □ No Are you wearing contacts today? □ Yes □No

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? (Check all that apply)

	Abscesses		Acne		Alopecia		Autoimmune Disorders		Bacterial Infections
	Bell's Palsy		Blood Disorders		Cancer		Circulatory Disorders		Clotting Issues
	COVID 19		Cysts		Dandruff		Dermatitis		Diabetes
	Eczema		Epilepsy		Fever Blisters		Fibromyalgia		Folliculitis
	Fungal Infections		Gland Disorders		Gout		Hair Transplant		Healing Difficulties
	Heart Attack or Angina		Herpes		High Blood Pressure		HIV/AIDS		Hives
	Hyperpigmentation		Inflammatory Disorders		Ingrown Hairs		Keloids		Keratosis
	Keratosis Pilaris		Lupus		Lyme Disease		Melasma		Mental Health Issues
	Migraines		Organ Transplant		Parasitic Infections		Photosensitivity		Seizures
	Shingles		Spider Veins		Staph/MRSA		Stroke		Tinea Versicolor
	Varicose Veins		Viral Infections		Vitiligo		Warts		Other Disease, Infection, or Health Problem

Do you presently have any type of rash, skin irritation, lesions, or open wounds? □ Yes □ No
Do you have any type of communicable disease? □ Yes □ No
Have you ever undergone Accutane therapy (isotretinoin)? □ Yes □ No If yes, dates of therapy: _____
Please list your current medications (include all vitamins/supplements/hormones/topicals):

_____

_____

What type of birth control do you utilize? _____
Recent changes in contraceptive? □ Yes □ No
Are you currently pregnant or do you think you might be pregnant? □ Yes □ No
Are you having your period now? □ Yes □ No
Are you lactating? □ Yes □ No
Are you presently undergoing any form of hormone therapy? □ Yes □ No
Do you have any metal or other implants? □ Yes □ No If Yes, what and where?_____

_____

Do you have an implanted electronic monitoring device? □ Yes □ No Are you taking blood thinners? □ Yes □ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (Check all that apply)

	Apples		Aspirin		Bee Stings		Cinnamon		Dairy/Milk		Eggs		Gluten
	Iodine		Medication		Nuts		Shellfish		Sulfur/Sulfa		Trees		Other

Please list any allergies you have:_____

_____

Do you have allergies to foods or ingredients? □ Yes □ No If so, please list:_____

_____

_____

Have you had any tattoos or body piercings in the past month? □ Yes □ No
Do you have any circulatory or respiratory problems? □ Yes □ No
Have you smoked or used tobacco products in the last 6 months? □ Yes □ No
List any scents you do not like:_____
Describe your facial cleansing and maintenance routines (including products used):_____

_____

Do you use sunscreen every day? □ Yes □No
Are you satisfied with the results you have achieved with your current skin care routine? □ Yes □ No
Please list any other concerns you would like to discuss today:_____

_____

_____

Do you have any other health conditions that we should know about?_____

_____

Have you ever used any facial, skin, or hair products that caused a bad reaction? □Yes □ No
If so, explain:_____

I read, understood, and completed this questionnaire completely and truthfully. I agree this constitutes full disclosure and supersedes any previous verbal or written disclosures. I understand that withholding information or providing incorrect information may result in damage to my skin or body from treatments received. The treatments I receive are completely voluntary, and I assume full responsibility for learning and understanding the risks of all treatments provided to me and the results therefrom. By receiving any services, I agree that I have been fully informed of the nature of the procedure, the risks involved, the possibility of a negative outcome, including but not limited to bruising, infection, scarring, temporary or permanent injury or nerve/muscle impact, paralysis, or even death. By receiving services, I acknowledge all my questions have been answered, and I am proceeding with the treatment notwithstanding any risks known or unknown. I agree to follow all pre- and post-treatment instructions and recommendations. A negative outcome is not a basis for a partial or full refund for services provided. I release the treatment provider(s), David Hammett, MD, The Hammett Clinic, LLC, Kathleen Cauthen, L.E., and Skinology, LLC from all liability of any kind for any/all service(s) received or any product utilized or purchased. I have read and agreed to the policies currently in effect. The treatment provider(s) and practice(s) noted above reserve the right to refuse any service to any person for any reason. Payment in full is to be received at the time of service. Returned checks will incur an additional charge of $50.00.

Date: _____ Signature:_____