STUART LIPTON, M.D.
CLIENT CONSULTATION FORM

Name _____
Address _____
City _____State_____Zip_____
Home #_____Business #_____
Fax #_____Mobile #_____
Occupation _____
Date of Birth _____
Marital Status_____Spouse'sName_____
Family Physician _____Phone # _____
Dermatologist _____Phone # _____
Last seen: [ ] Physician [ ] Dermatologist [ ] Other _____
Reason for Last Doctor's Visit: _____Date _____

MEDICAL HISTORY

Check Box Where Applicable / Fill in With Details

- ☐ Accutane
- ☐ Allergies_____
- ☐ Artificial Implants
- ☐ Birth Control_____
- ☐ Blood Thinner
- ☐ Claustrophobia
- ☐ Depression
- ☐ Distended Capillaries
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Hyper/Hypo Pigmentation
- ☐ Insomnia
- ☐ Medication_____
- ☐ Nail Disorders
- ☐ Phlebitis
- ☐ Pregnant
- ☐ Retin-A™
- ☐ Seborrhea
- ☐ Skin Cancer_____
- ☐ Underweight/Overweight
- ☐ Other_____
- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Contact Lens
- ☐ Diabetic
- ☐ Eczema
- ☐ Fever Blisters
- ☐ Hepatitis
- ☐ HIV
- ☐ Hyper/Hypo Thyroid
- ☐ Lupus
- ☐ Metal Plates or Pins
- ☐ Pacemaker
- ☐ Plastic Surgery
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Sensitivities
- ☐ Surgeries
- ☐ Vitamins _____

PERSONAL SKIN CARE HISTORY

Please Check Current Products You Use:

- ☐ Eye Make-Up Remover
- ☐ Skin Freshener (Toner, Astringent)
- ☐ Eye Cream
- ☐ Facial Scrub
- ☐ Body Lotion / Cream
- ☐ Sunscreen # _____
- ☐ Cleansing Cream / Lotion
- ☐ Day Cream
- ☐ Neck Cream
- ☐ Exfoliants
- ☐ Body Scrub
- ☐ Other: _____
- ☐ Facial Soap
- ☐ Night Cream
- ☐ Mask
- ☐ Body Soap
- ☐ Hand Cream

STUART LIPTON, M.D.
PERSONAL EVALUATION QUESTIONNAIRE

1. How did you hear of our office? _____
   _____
2. What is your major reason for being here today? _____
   _____
3. What skin type and / or problems do you feel you have? _____
   _____
4. Have you ever had a facial treatment before? If yes, where and when? Was it a beneficial experience? _____
   _____
5. Have you ever had a reaction to a cosmetic or skin care product? Please describe. _____
   _____
6. Have you ever had a body/ bust treatment? _____
   _____
7. Where do you purchase most of your face and body care products?_____
   _____
8. How much time do you spend on your daily skin care / make-up routine? _____
   _____
9. How do you feel about your body and skin conditions? What would you like to improve? ____
   _____
10. Do you tend to tan or burn? _____
11. Do you smoke? _____
12. Do you exercise? How Much? _____
13. How Much sleep do you get per night? _____
    _____

14. How much do you drink of the follow:	Little	Moderate	Heavy
Water	☐	☐	☐
Coffee	☐	☐	☐
Tea	☐	☐	☐
Alcohol	☐	☐	☐
Soft Drinks	☐	☐	☐

15. Would you like to be on our mailing list for promotions and classes? _____ __
    _____
16. Are you interested in long or short term office treatment? _____
    _____
17. Are you pleased with your current products? _____
    _____
18. Have you ever been waxed with depilatory wax before?
    _____

OFFICE POLICIES

I understand fully and agree to comply with all the office policies listed below:

1. We do not wax anyone with Accutane, Retin-A[tm], or other medications/ productions that exfoliate or thin the skin. We do not wax anyone undergoing chemotherapy or radiation treatments.
2. We will not treat clients with questionable medical conditions such as herpes simplex (cold sores, fever blisters), open wounds or sores, healing incisions, infectious diseases, ect. We do not massage clients undergoing cancer, diabetic, or systemic treatments or any other specific contra-indications to body treatments.
3. We require a minimum of 24 hours advance cancellation notice. Any client giving less will be charged that full fee of service reserved.
4. I understand that the service received here are not a substitute for medical care and any information provided by the esthetician is for educational purposes only.
5. All information received by the client on this chart is completely private and confidential.
6. We do not give cash refunds.
7. Defective products must be returned within 10 days purchase to receive credit.

Date_____ Signature_____