Iowa Plastic Surgery

CONSULTATION QUESTIONNAIRE

Name _____ Age _____ Date____/____/_____

Treatment Area _____ Fitz Skin Type I II III IV V VI Pregnant _____Yes _____No

Current Medications _____

Allergies _____

History	Yes	No	N/A	Date
Recent Sun Exposure	X	X	X	_____
Previous Laser Treatments	X	X	X	_____
Hair Removal - Waxing, Plucking, Electrolysis	X	X	X	_____
Accutane, last 6 months	X	X	X	_____
Gold Therapy	X	X	X	_____
Coagulopathies	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____
Implants/Surgeries in treatment area	X	X	X	_____
Decreased sensation/Numbness in treatment area	X	X	X	_____

Initial

_____ Benefits of procedure discussed
_____ Contraindications reviewed
_____ Risks reviewed
_____ Probability of success reviewed
_____ Alternative procedures available
_____ Consent signed
_____ Verbal and written post-treatment instructions given to patient
_____ Pre-op photos taken

Comments: