CONSULTATION FORM – **SKIN CARE**

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| Date: | Click or tap to enter a date. |

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| --- | --- |
| First and last name:  | Click or tap here to enter text. |
| Gender: | Choose an item. | Age: | Click or tap here to enter text. |
| Height: | Click or tap here to enter text. | Weight: | Click or tap here to enter text. |
| Occupation: | Click or tap here to enter text. | Marital Status:  | Choose an item. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |
| E-mail: | Click or tap here to enter text. |

Please write your e-mail address legibly. The program will be e-mailed to you.

Please send along with the form a few photos of your face and neck that were taken in full light and clarity.

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| How did you hear about us? Google, Instagram, Facebook, Twitter, friends, other? |
| Click or tap here to enter text. |
| Please provide your transaction details (date of deposit, name, surname and your PayPal e-mail address):  |
| Click or tap here to enter text. |
| If you already have received a treatment program from us, please indicate how many courses you received and how effective was your previous course: |
| Click or tap here to enter text. |
| Please select your treatment: |
| [ ]  Facial & Neck Rejuvenation [ ]  Skin Care and Anti-Aging [ ]  Acne Treatment [ ]  Eczema Treatment |
| Please explain your skin problems. |
| Click or tap here to enter text. |
| Have you ever received chemical peels, laser services, microdermabrasion, dermabrasion, botox, juvederm, dermal fillers or any other skin treatments in the last two years? If Yes, please explain and mention the time. |
| Click or tap here to enter text. |
| What kind of skincare products do you currently use? |
| Click or tap here to enter text. |
| Please list all medications or natural supplements you are currently taking, and for what conditions? |
| Click or tap here to enter text. |
| Do you have skin allergies? Do you have any medication or food allergies? |
| Click or tap here to enter text. |
| Have you used or been prescribed any medications (topical or oral) for acne control? If yes, please specify what and date last used: |
| Click or tap here to enter text. |
| Are you exposed to extreme or prolonged sunlight? |
| Click or tap here to enter text. |
| What type of skin do you have? [ ]  Dry [ ]  Normal [ ]  Oily |
| Have you received any of these hair removal services in the last 45 days?  |
| [ ] Waxing [ ] Sugaring [ ] Threading [ ] Electrolysis/Laser[ ] Depilatory Cream [ ] Shaving [ ]  None |
| Do you smoke? If so, on average, how many cigarettes per day? |
| Click or tap here to enter text. |
| Did you drink alcohol? How much? |
| Click or tap here to enter text. |
| Do you exercise? What kind of exercise and how many hours per week? |
| Click or tap here to enter text. |
| How many hours do you sleep at night? Do you have problems such as insomnia or excessive sleepiness? Please explain. |
| Click or tap here to enter text. |
| Do you have a stressful life? |
| Click or tap here to enter text. |
| If you have any physical or mental illnesses, please fully explain. |
| Click or tap here to enter text. |
| Write your current diet plan (Breakfast, lunch, dinner, snacks, etc.) |
| Click or tap here to enter text. |
| How many caffeinated beverages do you consume per day? |
| Click or tap here to enter text. |
| **WOMEN’S QUESTIONS:** |
| Are you pregnant or breastfeeding? |
| Click or tap here to enter text. |
| Do you take birth control pills? If yes, specify the type and amount of use. |
| Click or tap here to enter text. |
| Are you going through menopause? Are you experiencing any symptoms during menopause? Please explain. |
| Click or tap here to enter text. |

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| **MEN’S QUESTIONS:** |
| What is your current shaving system?  |
| [ ] Razor [ ] Electric [ ] Other: Click or tap here to enter text. |
| Do you experience irritation from shaving?  |
| Click or tap here to enter text. |

Name and Signature:

Click or tap here to enter text.

Please draw your signature here

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1. The applicant is responsible for the accuracy of the information in the form. The applicant must complete the treatment form accurately and keep the physician fully informed of his or her condition, illnesses and medications.
2. I allow the use of my photos on Dr. Nasirzadeh's website and social networks.
3. I have read the FAQ page thoroughly, and I am fully aware of the treatment process and the chance of getting a result.