Skin Evaluation Form

Patient ______________________________________ Race________________ Age_________

Please fill in the following description of your facial complexion. This information is necessary for us to design a skin program for you.

Conditions **(Circle yes or no)** **Office Notes**

Y or N Sun Damage ______________________________

Y or N Brown Spots (or splotchy, uneven skin color) ______________________________

Y or N Upper Lip Lines – Deep ____ Fine____ ______________________________

Y or N Freckles ______________________________

Y or N Wrinkles - Deep ____ Fine____ ______________________________

Y or N Hard bumps under skin ______________________________

Y or N Clogged pores ______________________________

Y or N Excessive oiliness ______________________________

Y or N Acne ______________________________

Y or N Pimples – Often ____ Sometimes____ ______________________________

Y or N Blackheads ____ Whiteheads ____ ______________________________

Y or N Dry Patches ______________________________

Y or N Visible Exposed Blood Vessels ______________________________

What type of skin do you have? ____Normal to Dry ____Normal to Oily Do you tan? ____Easily ____Burn

Any chronic skin or medical disorders? ____Psoriasis ____Dermatitis ____Fever Blisters ____Hepatitis

List medications/supplements you are using: ____

Do they make you photo-sensitive? Y or N

What cosmetic ingredients/medications are you allergic: ______________________________________

Are you using: Retin A Y or N What strength? ________ How Long? _________

Accutane Y or N Zovirax Y or N Taking Antibiotic oral/topical Y or N

Tetracycline Y or N Any facial scarring? Y or N Facial Region: ______________________

Have you had or planning to have any facial surgery? Y or N

Any prior cosmetic peels? ____Salon ____TCA ____Phenol ____Other Date ____________________

Pregnant? Y or N Breastfeeding? Y or N Oral Contraceptives? Y or N Hormone Imbalance? Y or N

Date of your last period? _______________ Excessive Hair face/breasts? Y or N

Facial Hair Removal? ____Wax ____Other Date:__________________________

Please check the products you are currently using and list the brand names:

___Cleanser ______________________ ____Soap __________________ ____Toner __________________

____Moisturizer ___________________ ____Night Cream _____________ ____Other __________________

____Eye Cream ____________________ ____Astringent ______________ ____Mask ___________________

____Scrub _______________________ ____Sunscreen______________

Patient Informed Consent Particle Skin Resurfacingsm

This form is to provide you with information that you may need to make a decision regarding Particle Skin Resurfacingsm with the Derma CareTM Systems.

1. I voluntarily request that Joseph F. Bianca, MD and such associates, technical assistants and other healthcare providers he may deem necessary are authorized to treat my condition. I acknowledge having been informed that this procedure is intended to remove surface skin to improve the vitality of the skin.
2. I acknowledge that, while the goal of such a procedure is the removal of damaged skin, the realistic results average a 50-75% improvement. I acknowledge that the practice of medicine is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some patients are greatly improved and for others no appreciable improvement is noticed. I also acknowledge that there is a risk of skin pigment change in some individuals.
3. I also realize that risks and hazards may occur in connection with this procedure. The following may occur on rare occasions worsening or unsatisfactory appearance, creation of additional problems such as: poor healing or skin loss, nerve damage, painful or unattractive scarring, recurrence of the original condition.
4. I acknowledge my obligation to follow the written and spoken instructions closely

I understand that multiple treatments are required. The cost of these were disclosed prior to the first treatment.

I have received a thorough explanation of my preoperative and postoperative instructions. I understand that should I have additional questions, I should not hesitate to call.

I certify that I have read and fully understand the contents of this consent form and authorize the performance of Particle Skin ResurfacingSM by Dr. Bianca and /or his assistants.

______________________________ ______________________

Patients Signature **Date**

______________________________ ______________________

Witness Signature **Date**