

EXPERTS IN BEAUTIFUL SKIN



NALINI G. PRASAD, MD

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

Reason for visiting us today? _____

Consultation Information:

What conditions currently apply to your skin?

- | | |
|---|---|
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Enlarged pores |
| <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Lip lines |
| <input type="checkbox"/> Acne/Acne scars | <input type="checkbox"/> Age spots |
| <input type="checkbox"/> Unwanted hair | <input type="checkbox"/> Fine lines |
| <input type="checkbox"/> Facial capillaries | <input type="checkbox"/> Wrinkles |

Please indicate which treatments you are interested in:

- | | |
|---|--|
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Botox/Dysport | <input type="checkbox"/> Mole Removal |
| <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Radiesse |
| <input type="checkbox"/> Capillaries | <input type="checkbox"/> Restylane/Perlane |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Sculptra |
| <input type="checkbox"/> FotoFacial | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Fractional Resurfacing | <input type="checkbox"/> Skin Surgery |
| <input type="checkbox"/> Hair Restoration- Revage 670 | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Teeth Whitening |
| <input type="checkbox"/> Leg Vein Therapy | <input type="checkbox"/> Waxing/Tinting |

Areas of Interest for Laser Hair Removal (check all that apply):

- | | | | |
|-----------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Lip | <input type="checkbox"/> Bikini | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Underarm | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Sideburn | <input type="checkbox"/> Lower Legs | <input type="checkbox"/> Buttocks | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Thighs | <input type="checkbox"/> Areolas | <input type="checkbox"/> Arms |

What would you like to achieve with your treatment(s) and/or skin care recommendations?
