

Skin Spa

North Scottsdale Dermatology
Gary McCracken, M.D.
14275 N 87th Street, Ste. 109
Scottsdale AZ 85260

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell/Work #: _____

Email address: _____ May we contact you? Yes ___ No ___

Are You Wearing Contact Lenses? Yes ___ No ___ (Please remove if eyes are sensitive)

Are you currently using any of the following treatments/products?

Tanning Salons	Y ___ N ___	Retin A	Y ___ N ___
Waxing	Y ___ N ___	Renova	Y ___ N ___
Electrolysis	Y ___ N ___	Differin	Y ___ N ___
Depilatories	Y ___ N ___	Kinerase	Y ___ N ___
Biore Strips	Y ___ N ___	Chemical Peels	Y ___ N ___
Microdermabrasion	Y ___ N ___	Botox Injections	Y ___ N ___
Glycolic Homecare	Y ___ N ___	Collagen Injections	Y ___ N ___

If yes, how often are you using these treatments/products? _____

Have you ever used or are currently using Accutane or Gold Therapy? Yes ___ No ___
If yes, when? : _____

Have you ever received any type of peel? Yes ___ No ___ If yes, has it been within the last 14 days? Yes ___ No ___ What type of peel was it? : _____

Do you smoke? Yes ___ No ___

Are you prone to cold sores? Yes ___ No ___ If yes, how often & last one? _____

Have you ever received any type of laser or IPL treatment? Yes ___ No ___ If yes, when was your last treatment and what was it? _____

Are you currently participating in any vigorous aerobic or athletic activities?
Yes ___ No ___ If yes, what type? _____ How often? _____

Do you have any allergies? Yes ___ No ___

Citrus _____	Apples _____
Grapes _____	Milk _____
Aloe Vera _____	Hydroquinone _____
Aspirin _____	Other _____
Perfumes _____	If other, please describe _____

Do you have any sensitivity to products with an alcohol base? Yes ___ No ___
If yes, please describe: _____

(Please note that antibiotics increase your sensitivity level)

Are you currently taking any medications? Yes ___ No ___ If yes, please describe _____

Please describe your skin: (Check all that apply)

Thick ___	Dehydrated ___	Hyperpigmentation ___
Thin ___	Freckled ___	Rosacea ___
Saggy ___	Acne Prone ___	Wrinkled ___
Firm ___	Sun-damaged ___	Psoriasis ___
Oily ___	Blotchy ___	Eczema ___
Dry ___	Sm Pores ___	Broken Capillaries ___
Normal ___	Lg Pores ___	Sensitive ___
Combination ___	Dry Patches ___	Resilient ___

Color of your hair:

White ___	Lt Brown ___
Blonde ___	Dk Brown ___
Red ___	Black ___
Reddish Blonde ___	Grey ___

Color of your eyes:

Grey ___	Hazel ___
Blue ___	Lt. Brown ___
Green ___	Dk. Brown ___

Color of your skin:

Pale/White ___	Dk. Brown ___
Medium ___	Soft Black ___
Reddish ___	Black ___
Lt. Brown ___	Sallow ___

What is your ethnic make-up? _____

Please describe you skincare routine:

Morning: _____

Evening: _____

How much water do you consume on a daily basis? _____

Describe any cosmetic improvements you would like to see with your skin: _____

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRIVACY

* You may refuse to sign this acknowledgement*

I, _____, have received a copy of North Scottsdale Dermatology Skin Spa's Notice of Privacy Practices.

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other _____