

# THE WASHINGTON ENT GROUP

BOARD CERTIFIED OTOLARYNGOLOGY-HEAD AND NECK SURGERY  
BOARD CERTIFIED AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY  
FELLOW OF THE AMERICAN COLLEGE OF SURGEONS

**Patient Name:** \_\_\_\_\_ **Pt# :** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zipcode:** \_\_\_\_\_

**Phone Numbers:** (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ (FAX) \_\_\_\_\_

**Sex (circle one):** F M **Birth Date:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

## Cosmetic issues of interest to you (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Botox Cosmetic Therapy | <input type="checkbox"/> Acne                   |
| <input type="checkbox"/> AHA & Glycolic Peels   | <input type="checkbox"/> Skin Care advise       |
| <input type="checkbox"/> Collagen Therapy       | <input type="checkbox"/> Jan Marini products    |
| <input type="checkbox"/> Skin rejuvenation      | <input type="checkbox"/> Birthmarks             |
| <input type="checkbox"/> Retin-A                | <input type="checkbox"/> Age spots              |
| <input type="checkbox"/> Micro-dermabrasion     | <input type="checkbox"/> Sunscreen advice       |
| <input type="checkbox"/> Reducing wrinkles      | <input type="checkbox"/> Facials/Eye treatments |
| <input type="checkbox"/> Chemical Peels         | <input type="checkbox"/> Hair removal           |
| <input type="checkbox"/> Laser resurfacing      | <input type="checkbox"/> Removing facial veins  |

## How did you hear about us?

My Physician (Name/address): \_\_\_\_\_

Phone Book (specify which ad): \_\_\_\_\_

A Friend or Family member: \_\_\_\_\_

A seminar/open house where I saw the doctor: \_\_\_\_\_

Radio: \_\_\_\_\_

Magazine: \_\_\_\_\_

**Enjoy your consultation with Dr. Scott McNamara!**

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## PATIENT PROFILE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Pt# : \_\_\_\_\_

What is your occupation? \_\_\_\_\_  
Do you participate in vigorous aerobic activity or sports? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_  
Are you pregnant or lactating? Yes \_\_\_\_\_ No \_\_\_\_\_ (If so, decline treatment)  
Do you currently have a sunburn/windburn? Yes \_\_\_\_\_ No \_\_\_\_\_ (If so, decline treatment)  
Do you go to tanning booths? Yes \_\_\_\_\_ No \_\_\_\_\_ (If within past three weeks, decline treatment)  
Do you have facial waxing/electrolysis/or use depilatories? Yes \_\_\_\_\_ No \_\_\_\_\_ (wait 5 days between treatments)  
Are you currently using Retin-A/Renova? Yes \_\_\_\_\_ No \_\_\_\_\_ How long? \_\_\_\_\_ How frequently? \_\_\_\_\_  
Where applied? \_\_\_\_\_ (Discontinue use 7 days before and after treatment)  
Are you currently using Accutane? Yes \_\_\_\_\_ No \_\_\_\_\_ How long? \_\_\_\_\_  
Have you had collagen injections recently? Yes \_\_\_\_\_ No \_\_\_\_\_ (Wait 7 days between treatments)  
Have you ever had a peel? Yes \_\_\_\_\_ No \_\_\_\_\_ Within the last 14 days? Yes \_\_\_\_\_ No \_\_\_\_\_  
What kind? \_\_\_\_\_  
Describe your reaction: \_\_\_\_\_  
Have you recently had facial surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ Describe: \_\_\_\_\_  
Have you recently had laser resurfacing? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_  
Are you allergic to (Check all that apply) milk \_\_\_\_\_ apples \_\_\_\_\_ citrus \_\_\_\_\_ grapes \_\_\_\_\_ aloe vera \_\_\_\_\_ aspirin \_\_\_\_\_  
hydroquinone \_\_\_\_\_ kojic acid \_\_\_\_\_  
Any other allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what? \_\_\_\_\_

### Tell us about your skin; describe it by checking all that apply:

Normal \_\_\_\_\_ Dry \_\_\_\_\_ T-Zone/Combination \_\_\_\_\_ Oily \_\_\_\_\_ Acne \_\_\_\_\_ Comedones \_\_\_\_\_ Milia \_\_\_\_\_  
Breakouts \_\_\_\_\_ Cysts \_\_\_\_\_ Scarring \_\_\_\_\_ Large pores \_\_\_\_\_ Small pores \_\_\_\_\_ Flord \_\_\_\_\_ Rosacea \_\_\_\_\_  
Asphyxiated \_\_\_\_\_ Freckled \_\_\_\_\_ Sun-damaged \_\_\_\_\_ Uneven/blotchy \_\_\_\_\_ Mature \_\_\_\_\_ Wrinkled \_\_\_\_\_  
Fine lines \_\_\_\_\_ Saggy \_\_\_\_\_ Firm \_\_\_\_\_ Sallow \_\_\_\_\_ Melasma \_\_\_\_\_ Perfume-stained \_\_\_\_\_  
Hypo-pigmented \_\_\_\_\_ Post-inflammatory hyper-pigmentation \_\_\_\_\_ Dehydrated (lacking moisture) \_\_\_\_\_  
Do you consider your skin SENSITIVE \_\_\_\_\_ or RESILIENT \_\_\_\_\_? (Check)

Eye Color: Blue \_\_\_\_\_ Green \_\_\_\_\_ Hazel \_\_\_\_\_ Grey \_\_\_\_\_ Lt. Brown \_\_\_\_\_ Dk. Brown \_\_\_\_\_  
Hair Color: Blonde \_\_\_\_\_ Red \_\_\_\_\_ Lt. Brown \_\_\_\_\_ Med. Brown \_\_\_\_\_ Dk. Brown \_\_\_\_\_ Black \_\_\_\_\_  
Grey/Silver \_\_\_\_\_ White \_\_\_\_\_  
Skin Tone: Pale/White \_\_\_\_\_ Light \_\_\_\_\_ Medium \_\_\_\_\_ Reddish \_\_\_\_\_ Freckles \_\_\_\_\_ Lt. Olive \_\_\_\_\_  
Med. Olive \_\_\_\_\_ Dk. Olive \_\_\_\_\_ Brown \_\_\_\_\_ Black \_\_\_\_\_

What is your heritage? \_\_\_\_\_  
Are you using Glycolic/AHA home care products? Yes \_\_\_\_\_ No \_\_\_\_\_ Describe \_\_\_\_\_  
How does your skin react to them? \_\_\_\_\_  
Have you ever used any products that caused a bad reaction? Yes \_\_\_\_\_ No \_\_\_\_\_ Describe \_\_\_\_\_  
Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you develop cold sores/fever blisters: Yes \_\_\_\_\_ No \_\_\_\_\_  
Is so, when was your last breakout? \_\_\_\_\_  
Do you have telangiectasia/broken surface capillaries? Yes \_\_\_\_\_ No \_\_\_\_\_  
What is your home care regimen? \_\_\_\_\_  
What is it about your skin that bothers you that you would like to have corrected? \_\_\_\_\_