



**Paul E. Goco, MD**  
Board Certified Facial Plastic Surgeon  
**Nicole D. Wissing, MS, PA-C**  
Physician Assistant

**Mandi Perry • Mia Jones • Tricia King**  
Licensed Aestheticians  
1370 Gateway Blvd., Suite 240  
Murfreesboro, TN 37129  
**615-848-9223**

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ @ \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Emergency Contact & Relation \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Gender (Please circle): Male Female Marital Status: \_\_\_\_\_ Race(optional): \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

What Pharmacy do you use? \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our facility? \_\_\_\_\_

Would you like to be added to our email list? Yes No

**FINANCIAL INFORMATION:**

We do not bill insurance companies for cosmetic or esthetic services because they are not “medically necessary”. The initial consultation fee for Dr. Goco is \$100.00. This fee will be applied to your first procedure that you schedule with him as long as you schedule within 60 days. The initial consultation fee for Aesthetic services is \$50.00. This fee includes a 1 ½ hour Skincare evaluation with Complexion Analysis and/or Makeup Consultation and 1 complimentary follow up visit. Please note that this fee is non-refundable, even if you decide not to pursue cosmetic or esthetic services. Payment is expected at the time of visit. We accept cash, checks, Visa, MasterCard, American Express and Discover. All product returns require prior approval. Unopened, unused, and unmarked products may be returned for account credit within 30 days of purchase. Due to recent changes in product manufacturing restrictions, we will no longer be able to issue a credit for opened, used, or marked products.

\_\_\_\_\_  
SIGNATURE DATE

**PHOTOGRAPH AUTHORIZATION**

I give my permission to Dr. Goco and the Goco Center for Aesthetics to take photographs of my treatment areas for diagnostic purposes and to document my response to treatments. I agree that these photographs are the property of Dr. Goco and the Goco Center for Aesthetics and I give my permission to use these photographs for teaching purposes, for use in scientific publications, books, journals, lectures, seminars, and electronic media. It is understood that in any such publication, I shall not be identified by name and that appropriate measures shall be made to protect my identity. I understand that I will not receive any compensation for the use of my photographs.

\_\_\_\_\_  
SIGNATURE DATE

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## YOUR HEALTH

Please list any major medical problems \_\_\_\_\_

List all prescribed or over the counter medications, vitamins, herbal remedies, and topical medications \_\_\_\_\_

List any prior chemical peels, facial surgery, or other surgery with the date \_\_\_\_\_

List any allergies you have to medicines, foods, skin care products, or environmental substances (mold etc.) \_\_\_\_\_

Are you currently using any prescription skin care? \_\_\_\_\_

## CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

(please print)

1. What is the reason for your visit today? \_\_\_\_\_
2. What special areas of concern do you have? \_\_\_\_\_

### EXPECTATIONS and HISTORY

3. Which conditions would you like to improve?
  - Acne Scarring
  - Acne
  - Age spots
  - Enlarged pores
  - Fine lines & wrinkles
  - Pigmentation
  - Broken capillaries
  - Stretch marks
  - Surgical/facial scars
  - Other \_\_\_\_\_
4. How would you describe your skin?(circle one) **NORMAL/DRY/OILY/COMBINATION/SENSITIVE/ACNE PRONE/SUN DAMAGED**
5. How would you rate your skin? (circle one)
  - Always Burns, never tans
  - Burns easily, tans slightly
  - Burns moderately, tans gradually
  - Seldom burns, Always tans well
  - Rarely burns, Deep tan
  - Never burns, Deeply pigmented
6. Do you ever experience (circle all that apply) **FLAKINESS/TIGHTNESS/REDNESS/EXCESSIVE OILY SHINE DURING DAY**
7. What is your present skin regimen? (**please list product name/brand/when used per line below**)
  - Soap & water only \_\_\_\_\_
  - Cleanser \_\_\_\_\_
  - Toner \_\_\_\_\_
  - Masks/Scrubs \_\_\_\_\_
  - Moisturizer \_\_\_\_\_
  - Exfoliation \_\_\_\_\_
  - Sun block every day \_\_\_\_\_
  - Make Up \_\_\_\_\_
  - Other \_\_\_\_\_

8. With your current or your potential new skin care regimen: *(circle one)*
- How quickly do you need to see results? **QUICK/MODERATE/GRADUAL**
  - How much irritation can you accept? **NONE/LITTLE/MODERATE/PLENTY**
  - How much downtime can you tolerate? **NONE/ONE WEEK/2-3 WEEKS**
9. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin? **YES/NO**
10. Do you blush easily? **YES/NO**  
 If yes, what are the contributing factors? *(circle one)* **EMOTIONS/FOODS/TEMPERATURE CHANGES/OTHER**
11. Do you *(circle one)* **SUN BATHE/USE A TANNING BED?** HOW OFTEN? \_\_\_\_\_
12. Have you ever had? *(circle all that apply)*
- PEELS/MICRODERMABRASION/FACIAL SURGERY/COSMETIC SURGERY/BOTOX/COLLAGEN INJECTIONS/LASER RESURFACING**  
**HOW RECENTLY?** \_\_\_\_\_
13. Are you under treatment for any current skin condition? **YES/NO**  
 If yes, what? \_\_\_\_\_
14. Does your skin heal? **FAST/SCARS/PIGMENTS**
15. Do you bruise easily? **YES/NO**
16. Skin History *(circle all that apply)* **HERPES (Cold Sores)/FEVER BLISTERS/BLEMISHES/ROSACEA/ECZEMA/PSORIASIS**
17. Have you ever used *(circle all that apply)* **ACUTANE/RETIN-A/RENOVA/TOPICAL ANTIBIOTICS/DIFFERIN/AHA's**  
 If yes, when and for how long? \_\_\_\_\_
18. Any personal or family history of skin cancer? **YES/NO** Provide Detail\_\_\_\_\_
19. How would you describe your overall health? **EXCELLENT/GOOD/FAIR/POOR**
20. Have you any of the following, past and/or present?
- ACNE **YES/NO** WHEN\_\_\_\_\_
  - ALLERGIES **YES/NO**
  - ARTHRITIS or BURSITIS **YES/NO**
  - BLOOD PRESSURE **HIGH/LOW/NORMAL**
  - BREAST IMPLANTS **YES/NO**
  - CANCER **YES/NO**
  - CATARACTS **YES/NO**
  - CHOLESTEROL **HIGH/LOW/NORMAL**
  - CLAUSTROPHOBIC **YES/NO**
  - DIABETES **YES/NO**
  - DIARRHEA/CONSTIPATION **YES/NO**
  - ECZEMA **YES/NO**
  - EPILEPSY **YES/NO**
  - HAY FEVER **YES/NO**
  - HEADACHES **YES/NO**
  - HEART DISEASE/CONDITIONS **YES/NO**
  - HEPATITIS **YES/NO**
  - HIV/AIDS **YES/NO**
  - INFECTIONS **YES/NO**
  - LUPUS **YES/NO**
  - MENOPAUSAL **YES/NO**
  - METAL IMPLANTS **YES/NO**
  - PACE MAKER **YES/NO**
  - PHLEBITIS **YES/NO**
  - SERIOUS INJURY **YES/NO**
  - SLEEP PROBLEMS **YES/NO**
  - THYROID **YES/NO**
  - VARICOSE VEINS **YES/NO**
  - DO YOU SMOKE **YES/NO**
  - DO YOU WEAR CONTACT LENSES **YES/NO**

21. Have you ever had a reaction to?

COSMETICS/METALS/MEDICATION/FOOD/FRAGRANCE  
AIRBORNE PARTICLES/OTHER Explain\_\_\_\_\_

22. **FOR WOMEN:** Oral Contraceptives? YES/NO
- o Are you pregnant or trying to get pregnant? YES/NO
  - o Are you taking hormone replacement? YES/NO
  - o Do you experience hormone imbalances? YES/NO

23. **FOR MEN:** Do you shave with? **Electric Shaver/Razor**
- o Do you experience skin breakouts? YES/NO
  - o Do you have ingrown hair? YES/NO

**LIFESTYLE & DIET**

1. Is your stress level? **HIGH/MEDIUM/LOW**
2. Do you normally sleep well? **YES/NO**
3. Do you regularly exercise? **YES/NO**
4. Do you have food intolerances? **YES/NO** What? \_\_\_\_\_
5. Do you follow any special diet? **YES/NO**
6. Daily water intake? \_\_\_\_\_
7. How many cups of caffeinated beverage (coffee, tea, soft drinks) do you consume daily? **1-3 cups/ 4 or more**
8. In our treatment program, it may be necessary to recommend alterations to or additions to your in-home skin care regimen: Will this be OK with you **YES/NO**
9. **Do you smoke?** **YES/NO** How many? \_\_\_\_\_

Your aesthetician will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.**

<input type="checkbox"/> Skin care advice/Make-Up	<input type="checkbox"/> Chemical peel	<input type="checkbox"/> Neck wrinkles
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Injectable Treatments	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Hips
<input type="checkbox"/> Juvederm/Restylane/Radiesse	<input type="checkbox"/> Brown spots/age spots/freckle	<input type="checkbox"/> Legs
<input type="checkbox"/> Facial fine lines/wrinkles	<input type="checkbox"/> Drooping brow	<input type="checkbox"/> Facial Contouring
<input type="checkbox"/> Lines around the eyes	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Body Contouring
<input type="checkbox"/> Thin Lips/Lip Lines	<input type="checkbox"/> Nose size or shape	<input type="checkbox"/> Unwanted Hair
<input type="checkbox"/> Lines between brows	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Length/Fullness of Eyelashes
<input type="checkbox"/> Dark Circles under eyes	<input type="checkbox"/> Mole removal	<input type="checkbox"/> Tattoo Removal
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Scar revision	

**GCA Scheduling Policies effective Jan 2012:**

- A 50% Deposit will be required in order to schedule the following **procedures**:
  - Fractora
  - Fraxel/Thermage/Exilis
  - Tattoo Removal
  - Laser Hair Removal
  - Cosmetic Surgery
  
- *A forfeiture of all deposits will be assessed if procedures listed above are not cancelled within 48 hours and not kept with the exception of cosmetic surgery. Cosmetic Surgery will require a 2 week cancellation policy.*
  
- Cancellation & Appointments “not kept” Policy. Appointments **not** listed above.
  - GCA requires a 24 hour notice for any cosmetic or aesthetic appointment cancellation in order to avoid being assessed a fee.
  - For appointments that are not cancelled and not kept, a \$25 fee will be assessed for aesthetic appointments and a \$50 fee for cosmetic appointments.
  - GCA will ask that all fees be paid prior to scheduling another appointment.

We thank you in advance for your understanding.

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SIGNATURE

DATE