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**VELASHAPE CONSULTATION FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Date of Birth : \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**MEDICAL HISTORY**

Bleeding disorder, bruising	Y	N	Accutane within 6 months	Y	N	
Dermatologic conditions	Y	N	Infection/broken skin		Y	N
Photosensitive/photo allergic	Y	N	Pregnancy		Y	N
History of keloid scarring	Y	N	Fragile/intolerant skin		Y	N
Pacemaker/Defibrillator	Y	N	Malignancy		Y	N
Poorly controlled diabetes	Y	N	Phlebitis, Blood clots	Y	N	
Varicose Veins	Y	N				

List of medications: \_\_\_\_\_  
 Medical conditions: \_\_\_\_\_  
 List any allergies: \_\_\_\_\_  
 Surgical history: \_\_\_\_\_

**LIFESTYLE ASSESSMENT**

Diet: \_\_\_\_\_  
 Exercise: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Smoking: \_\_\_\_\_ Alcohol: \_\_\_\_\_

**TECHNICIAN TO FILL OUT**

Skin tone: \_\_\_\_\_ Area to be treated: \_\_\_\_\_  
 Level of cellulite \_\_\_\_\_ Technician: \_\_\_\_\_

**\*\*\*PLEASE CHECK ALL THAT APPLY\*\*\***

How did you hear about us? TV \_\_\_\_\_ Website \_\_\_\_\_ Other (Please List) \_\_\_\_\_

**\*\*\*TREATMENT WILL BE FORFEITED IF IT IS NOT CANCELLED 24HRS PRIOR TO YOUR APPOINTMENT. \*\*\***

**\*\*\*LATE PATIENTS WILL HAVE TIME DEDUCTED FROM THEIR APPOINTMENT\*\*\***