

# Laser & Skin Care

## Consultation



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Phone number sequential order for contacting you: ie: (Home, Cell, Work) 1st \_\_\_\_\_ 2nd \_\_\_\_\_ 3rd \_\_\_\_\_

Email Address: \_\_\_\_\_

Any restrictions for contacting you? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please list \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Female \_\_\_\_\_ Male \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact Number (s): \_\_\_\_\_

Whom may we thank for referring you/How did you hear about us? \_\_\_\_\_

### **General appearance or products of interest to you (please check all that apply).**

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Thin lips	<input type="checkbox"/> Birthmark
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Stretch marks _____
<input type="checkbox"/> BOTOX® Cosmetic	<input type="checkbox"/> Sun/brown/age spots	<input type="checkbox"/> Veins _____
<input type="checkbox"/> Juvederm/Restylane	<input type="checkbox"/> Facial /Neck /Chest Redness	<input type="checkbox"/> Unwanted hair _____
<input type="checkbox"/> Facial fine lines	<input type="checkbox"/> Excessive perspiration/sweating	<input type="checkbox"/> Cellulite/Fatty deposits _____
<input type="checkbox"/> Facial wrinkles	<input type="checkbox"/> Acne scars	<input type="checkbox"/> Other _____
<input type="checkbox"/> Facial folds	<input type="checkbox"/> Active acne	<input type="checkbox"/> Other _____

### **Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about my appearance.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

### **Client Health & Skin Care History**

1. Medications (prescription, over the counter, vitamins, herbal) \_\_\_\_\_

2. Allergies: (Circle all that apply) Milk, apples, citrus, grapes, aloe vera, aspirin, hydroquinone, latex ?

Any other allergies? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what? \_\_\_\_\_

3. Surgeries (including plastic surgery) \_\_\_\_\_

4. Medical Conditions / History of (Check all that apply):

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Neuro-muscular Disease     |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Mental Disease      | <input type="checkbox"/> Auto-Immune Disorders | <input type="checkbox"/> Bleeding/Clotting Problems |
| <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Other _____         |  |   |

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

5. Are you pregnant? Yes / No                      Breastfeeding? Yes / No
6. Do you smoke? Yes / No Amount Daily \_\_\_\_\_ Do you drink? Yes / No Amount Daily \_\_\_\_\_
7. List skin care products/make-up you currently use: \_\_\_\_\_
- 
8. In the past 3 months have you used: Retin-A, Renova, Differin, Accutane, Antibiotics (oral or topical)?  
If so, for how long? \_\_\_\_\_
9. Describe your skin (Circle all that apply):  Normal       Oily       Dry       Combination       Acne  
 Uneven/Blotchy       Mature       Wrinkled       Large pores       Rosacea
10. Have you had electrolysis, waxing or laser hair removal? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Have you ever had dermal fillers/implants (i.e. Collagen, ArteFill, Radiesse, Restylane, Perlane, Silicone, etc) in the areas you are considering having treatment? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Have you had any cosmetic peels? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type and when?  TCA \_\_\_\_\_  
 Glycolic/AHA \_\_\_\_\_  Laser \_\_\_\_\_  Phenol \_\_\_\_\_  Other \_\_\_\_\_
13. Have you ever had laser vein removal? Yes \_\_\_\_\_ No \_\_\_\_\_ Sclerotherapy? Yes \_\_\_\_\_ No \_\_\_\_\_
14. Ethnicity (Check all that apply):  Caucasian       Hispanic / Latino       Black       Mediterranean  
 Indian       East Indian       Asian       Other \_\_\_\_\_

**SKIN TYPE WORKSHEET**

Score	Analysis	0	1	2	3	4
	What color are your eyes?	Light Blue, Grey or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
	What is your natural hair color?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin? (unexposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, Blistering, Peeling	Blistering followed by Peeling	Burns, sometimes followed by peeling	Rarely Burns	Never had Burns
	To what degree do you turn brown?	Hardly or not at all	Light Color Tan	Reasonable Tan	Tan very easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1 Month Ago	Less than 2 Weeks Ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
	Fitzpatrick Skin Type:					
Total Score	I (0 -7)    II (8 - 16)    III (17 - 25)    IV (26 - 30)    V-VI (over30)					

The above information is true and accurate to the best of my knowledge.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

## Virtual Wish List

*If money was not an issue, what treatments/procedures would you be interested in receiving and/or what problem areas would you want to have addressed. This list will help us better serve you by identifying your desires. This information may be taken into consideration for monthly specials or when new services are added.*

*Once you have listed the treatment/procedures you are interested in, please go back and number each one in order of importance.*

\_\_\_\_\_

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