

## PERSONAL PROFILE & HEALTH HISTORY

Name: \_\_\_\_\_ Gender: Male / Female Age: \_\_\_\_\_ DOB: \_\_\_\_\_

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

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

E-mail: \_\_\_\_\_ (We will e-mail appointment reminders, as well as promotions, specials, and promotions on established or new procedures.)

Services rendered for laser treatments are considered cosmetic and not covered by insurance.

To ensure the safety and effectiveness of your treatment program, please complete the medical history questionnaire below.

### MEDICAL HISTORY:

1. Are you currently pregnant?  Yes  No
2. Are you currently breastfeeding?  Yes  No
2. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_
3. Since your family background affects your skin and its response to the treatment, please specify by circling your ethnic origin: Caucasian African American Hispanic  
Asian Native American Middle Eastern Mediterranean Other
4. Which skin areas would you like to consider for treatment? \_\_\_\_\_
5. Medications: Please list all medications, including prescription, over-the-counter, vitamins and supplements. \_\_\_\_\_  
\_\_\_\_\_
6. Allergies: If you are allergic to any medications, please list them along with your reactions. \_\_\_\_\_  
\_\_\_\_\_
7. What is your daily consumption of alcohol? \_\_\_\_\_
8. Medical History: Please check all that apply:

<input type="checkbox"/> Acne	<input type="checkbox"/> Herpes	<input type="checkbox"/> Port wine stain
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Burns or skin grafts	<input type="checkbox"/> Implants	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kaposi's sarcoma	<input type="checkbox"/> Shingles
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Keloid scars	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Lupus	<input type="checkbox"/> Tattoos
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Permanent makeup	<input type="checkbox"/> Vitiligo
<input type="checkbox"/> Gold therapy	<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Ovary disease	

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1. Are you currently being treated for any medical conditions?  Yes  No  
Explain: \_\_\_\_\_  
\_\_\_\_\_
2. Have you used Accutane or any other photosensitizing drug in the last 12 months?  Yes  No  
If so, how recently? \_\_\_\_\_
3. Do you have any active skin diseases or infection in the area to be treated?  Yes  No
4. Do you have any skin allergies?  Yes  No
5. Are you allergic to latex, lidocaine, or any lotions?  Yes  No
6. Are you currently using glycolic acid or Retin-A?  Yes  No
7. Have you had a chemical peel or facial within the last week?  Yes  No
8. What products are you currently using on your skin:  
\_\_\_\_\_

9. Have you had any permanent cosmetic tattooing in the area to be treated?  Yes  No
10. Do you have any metal or other implants?  Yes  No  
Where? \_\_\_\_\_
11. Have you had any surgical procedures performed in the area to be treated  
in the last 3 months, cosmetic or otherwise?  Yes  No
12. Have you had any previous vein treatment (i.e. laser, sclerotherapy, or stripping)?  Yes  No  
If so, how long ago? \_\_\_\_\_
13. Are you currently using (or have used within the last 6 months) a tanning bed or  
self-tanning cream?  Yes  No  
If yes, date of last use: \_\_\_\_/\_\_\_\_/\_\_\_\_
14. Have you been exposed to the sun within the last 4-6 weeks?  Yes  No  
If yes, appropriate date of last exposure: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name and location of your family doctor: \_\_\_\_\_  
Phone # of family doctor: \_\_\_\_\_

**(You may wait to sign below until after your consultation.)**

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultation explained the treatment and answered any question I had.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Physician/Technician: \_\_\_\_\_ Date: \_\_\_\_\_

## Skin Type Form

### Help Us Treat You the Right Way . . .

#### To our patients

One of the important parameters for the success of your treatment is the correct typing of your skin. Your doctor will consider your skin type when planning your treatment program for many anesthetic medical procedures – including laser skin rejuvenation, elimination of benign vascular and pigmented lesions with PhotoDerm® PL, and hair removal with EpiLight™ Hair Removal System.

Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by the doctor are:

- Genetic disposition
- Reaction to sun exposure and tanning habits

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color.

To help us determine your skin type and treat you the right way, please take a few minutes and complete this questionnaire.

#### Genetic disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	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 unexposed areas?	Many	Several	Few	Incidental	None

\_\_\_\_\_ Total score for Genetic Disposition

#### Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blisters, 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 within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

\_\_\_\_\_ Total score for Sun Exposure

### Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

\_\_\_\_\_ Total score for Tanning Habits

### Summary

Add up the total for each of the three sections for your Skin Type Score. This will give you a better evaluation of your skin type.

\_\_\_\_\_ Total score for Genetic Disposition

\_\_\_\_\_ Total score for Sun Exposure

\_\_\_\_\_ Total score for Tanning Habits

\_\_\_\_\_ Skin Type Score

### Your Fitzpatrick Skin Type

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-24	III
25-30	IV
Over 30	V-VI

With respect to signs of aging, please highlight those areas of the face that bother or trouble you. In the box provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome).

