PERSONAL PROFILE AND HEALTH HISTORY

Last Name: _____First:_____Middle:_____
Street Address: _____
City, State, Zip: _____
Home Phone: _____Work:_____Cell:_____
E-mail:_____Occupation:_____Date of Birth: _____
Primary Care Physician: _____ Phone: _____
How did you hear about us? _____

Please specify your genetic origin: □ African American □ Asian □ Caucasian □ Hispanic □ Mediterranean □ Middle Eastern □ Native American □ Other_____

		circle one	
Females:	Are you pregnant?	Y	N
	Are you breastfeeding?	Y	N
	Are you planning pregnancy during the course of your treatment?	Y	N
	During pregnancy did you develop hyper pigmentation or masking?	Y	N
	Do you have regular periods?	Y	N
	Are you going through menopause?	Y	N

Please complete the following items of the medical history. Please, always inform us of any change in your medical history and/or medications.

Please list all medications including prescription and over the counter drugs, vitamins, herbs, supplements._____
_____

	circle one	
Are you using any medications purchased outside the USA?	Y	N
Are you allergic to any medications?	Y	N

Please list **all medications** and reactions: _____

Medical History: Please check all that apply

□ Acne
□ Bleeding disorders
□ Botox®Cosmetic
□ Burns/skin grafts
□ Diabetes
□ Endocrine disorders
□ Epidermolysis bullosa
□ Filler Injections
□ Gold therapy
□ Heart disease
□ Hemorrhoids
□ Herpes
□ High blood pressure
□ Hirsutism
□ Hormone Replacement Rx
□ Implants
□ Kaposi's sarcoma
□ Keloid scars
□ Lupus erythematosus
□ Permanent makeup
□ Polycystic ovary disease
□ Port-wine stain
□ Precocious puberty
□ Psoriasis
□ Rosacea
□ Seizures
□ Shingles
□ Skin cancer
□ Tattoos
□ Thyroid disease
□ Vitiligo
□ Pacemaker
□ Cold sores/fever blisters
□ HIV
□ Hepatitis
□ _____

Please answer the following questions.

		circle one	
1.	Are you currently being treated for any medical condition?	Y	N
	a. Explain: _____		
2.	Have you ever seen a physician regarding your skin?	Y	N
3.	Do you have any active skin diseases or infection in the area to be treated?	Y	N

[1]This form must be completed for all new clients and for continuing clients whose last treatment was 1 year ago or more.
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SKIN TYPE

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 three main factors that influence skin type and the treatment program:

Genetic disposition **Reaction to sun exposure** **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) has a major impact on the evaluation of your skin color.

Please take a few minutes to fill-out this questionnaire, **circling** the **most appropriate** response.

Name: _____

Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light Blue, Gray, Green	Blue, Gray or Green	Hazel/Brown	Dark Brown	Brownish Black
What is the color of your hair?	Sandy Red	Blonde	Chestnut/ Dark Blonde	Dark Brown	Black
What is the color of your Non-exposed skin?	Reddish	Very pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles in unexposed areas?	Many	Several	Few	Incidental	None
				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, blistering, peeling	Blistering followed by peeling	Burn sometimes followed by peeling	Rarely burn	Never burn
To what degree do you tan?	Hardly or not at all	Light colored tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you tan 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
				Score for Reaction to 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
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always
				Score for Tanning Habits	▸

What color is the hair in the area to be treated?

				Fitzpatrick Skin Type Scale	
◂	**Genetic Disposition Score**			**I**	**0-7**
◂	**Reaction to Sun Exposure Score**			**II**	**7-17**
◂	**Tanning Habits Score**			**III**	**17-25**
◂	**Total Score**			**IV**	**25-30**
◂	**Skin Type**	◂	**RAS**	**V-VI**	**Over 30**

		circle one	
4.	Do you have any skin allergies?	Y	N
5.	Have you had skin cancer or pre cancerous lesions?	Y	N
6.	Do you have psoriasis/eczema in the area to be treated?	Y	N
7.	Are there any moles with hair in the area to be treated?	Y	N
8.	Are you allergic to latex, lidocaine, or any lotions?	Y	N
9.	Have you ever surgery in the area to be treated?	Y	N
10.	Have you had any previous laser treatments or other skin treatments to the area to be treated? Describe: _____	Y	N
11.	Have you /are you using medications such as Accutane? Date of last use_____		
12.	Are you using Retin-A, Renova, Differin, Tazorac? Concentration_____%	Y	N
13.	Are you using glycolic/AHA home care products?	Y	N
14.	What skin care products are you currently using? _____ _____		
15.	Do you smoke?	Y	N
16.	Do you sunbathe? If yes, approximate date of last sun exposure_____	Y	N
17.	Are you currently using, or have you used a tanning bed or self tanner? If yes, specify with date of last use_____	Y	N
18.	Do you use a sunscreen? Summer_____ SPF_____ Winter_____SPF_____	Y	N
19.	Do you use facial depilatories? _____ Hot Wax? _____	Y	N
20.	Does your skin remain discolored after healing from a cut?	Y	N

Please indicate which of the following concerns you have about your skin?

□ Aged skin	□ Sun damage	□ Rosacea	□ Age spots
□ Acne	□ Enlarged pores	□ Blackheads	□ Texture
□ Redness	□ Wrinkles	□ Whiteheads	□ Stretch marks
□ Leg veins	□ Hair removal	□ Oily skin	□ Isolated fat areas
□ Spider veins	□ Unevenness	□ Dry skin	□ Scars
□ Scarring	□ Hyper pigmentation	□ Sensitive skin	□ Melasma

What area would you like to treat?

□ Face & Neck □ Chest □ Arms □ Hands □ Back □ Legs □ Other_____

Please specify areas which you would like to consider for laser hair removal?

_____

_____

Please indicate the service you are interested in or would like more information on:

□ Laser skin rejuvenation	□ Rosacea treatment	□ Acne treatment
□ Laser vein treatment	□ Sun damage repair	□ Age spot treatment
□ Laser hair removal	□ Botox®Cosmetic	□ Injection Lipolysis/Lipotherapy
□ Pigment treatment	□ Filler injections	□ Stretch mark/Scar treatment
□ Wrinkle treatment	□ Redness/vessels	□ Melasma

I confirm that the answers to the questionnaire are true and correct.

Signature of Client: _____ Date:_____

Signature of Consultant: _____ Date:_____

Reviewed by Nurse: _____ Date: _____

Reviewed by Medical Director: _____ Date: _____

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