

CLIENT NAME: _____ BIRTHDAY: _____

CLIENT ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

PATENT HISTORY & CONSULTATION

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES NO
If yes explain:
DO YOU SMOKE? YES NO
ARE YOU CLAUSTROPHOBIC? YES NO
DO YOU WEAR CONTACTS? YES NO
HOW MUCH WATER DO YOU DRINK?
HOW MUCH CAFFEINE YOU DRINK?
HOW MUCH ALCOHOL DO YOU DRINK?
DO YOU GET COLD SORES? YES NO
DO YOU HAVE ANY ALLERGIES? YES NO
PLEASE CONSIDER FOOD, COSMETICS, DRUGS OR OCCUPATIONAL.
DO YOU HAVE LATEX ALLERGIES? YES NO
HAVE YOU EVER HAD A SKIN REACTION? YES NO
DO YOU FORM THICK OR RAISED SCARS? YES NO
WHAT IS YOUR PAIN TOLERANCE? HIGH LOW

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS INCLUDING VITAMINS? YES NO
PLEASE LIST:
HAVE YOU EVER USED RETIN A®? YES NO
HOW LONG AGO?
HAVE YOU EVER TAKEN ACCUTANE ®? YES NO
HOW LONG AGO?
ARE YOU CURRENTLY TAKING HORMONES? YES NO
PLEASE LIST (INCLUDE BIRTH CONTROL):

SUN EXPOSURE HISTORY

DO YOU USE SUNSCREEN DAILY? YES NO
DO YOU GO TO A TANNING SALON? YES NO
ARE YOU OUT IN THE SUN A LOT OR SUNBATHE ON A REGULAR BASIS? YES NO
HAVE YOU EVER LIVED IN THE SUNBELT? YES NO

FEMALES ONLY

DO YOU HAVE REGULAR PERIODS? YES NO
ARE YOU GOING THROUGH MENOPAUSE? YES NO
ARE YOU CURRENTLY PREGNANT OR BREAST FEEDING? YES NO

PHOTOGRAPHIC RELEASE: I GIVE MY CONSENT FOR PHOTOGRAPHS TO BE TAKEN AS PART OF MY TREATMENT PROCESS AND USED FOR MEDICAL, EDUCATIONAL AND PROMOTIONAL PURPOSES.

PATIENT SKIN CARE

HAVE YOU EVER SEEN A DERMATOLOGIST FOR YOUR SKIN? YES NO
HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? YES NO
HAVE YOU EVER HAD A CHEMICAL PEEL? YES NO
HAVE YOU EVER HAD MICRODERMABRASION? YES NO
HAVE YOU EVER HAD LASER OR IPL TREATMENTS? YES NO
HAVE YOU EVER HAD COLLAGEN, BOTOX OR OTHER SKIN INJECTIONS? YES NO
DO YOU HAVE ACNE CONCERNS? YES NO
DO YOU HAVE BROKEN CAPILLARIES? YES NO
DO YOU BLUSH EASILY? YES NO
DO YOU HAVE FACIAL DISCOLORATION OR PIGMENTATION CONCERNS? YES NO
HAS A PHYSICIAN EVER TOLD YOU HAD ROSACEA? YES NO
PSORIASIS? YES NO
ECZEMA? YES NO

WHAT TYPES OF SKIN CARE PRODUCTS DO YOU USE:

WHAT CONCERNS DO YOU HAVE ABOUT YOUR SKIN?

FITZPATRICK SKIN TYPE (SELECT THE ONE THAT BEST DESCRIBES YOU)

- Skin Type I :** Never Tans, Always Burns (extremely fair skin, blonde hair, blue/green eyes)
- Skin Type II:** Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
- Skin Type III:** Often tans, sometimes burns (medium skin, brown hair, brown eyes)
- Skin Type IV:** Always tans, never burns (olive skin, brown, black hair, dark brown/black eyes)
- Skin Type V:** Never burns (dark brown skin, black hair, black eyes)
- Skin Type VI:** Never Burns (black skin, black hair, black eyes)

I CONFIRM THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND THAT I HAVE NOT WITHHELD ANY INFORMATION THAT MAY BE RELEVANT TO MY TREATMENT. I ALSO UNDERSTAND THAT THE SERVICES OFFERED BY THE SKIN THERAPIST ARE NOT A SUBSTITUTE FOR MEDICAL CARE AND ANY INFORMATION PROVIDED IS FOR EDUCATIONAL PURPOSES AND ARE NOT INTENDED TO DIAGNOSE.

Signature

Date

Signature

date