

# The Laser Skin Center

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

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

Birthdate: \_\_\_\_\_

Best phone number to contact you regarding your treatment and where we may leave a message:

Home phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

VIP Email \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP phone no. \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

This information is necessary for your procedure. Please answer yes or no to the following questions:

## Medical History

Are you currently or within the last year under a physician's care? \_\_\_\_\_

Have you had any recent surgeries? \_\_\_\_\_ Location on body \_\_\_\_\_

Are you using any prescribed medications? List \_\_\_\_\_

Are you using any Herbal medications? List \_\_\_\_\_

Do you take an oral anti-coagulant (blood thinning) medication? List \_\_\_\_\_

Are you allergic to any cosmetic ingredients, medications or foods?

List \_\_\_\_\_

Please check any health problems, past or present:

\_\_\_\_\_ Seizures

\_\_\_\_\_ Hormonal Problems

\_\_\_\_\_ High Blood Pressure

\_\_\_\_\_ Vasovagal Syndrome

\_\_\_\_\_ Liver disease

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Heart Problems

\_\_\_\_\_ PCOS

\_\_\_\_\_ Skin Cancer (Type: \_\_\_\_\_)

\_\_\_\_\_ Cystic Acne

\_\_\_\_\_ Collagen

\_\_\_\_\_ Autoimmune (lupus,  
Schleroderma)

\_\_\_\_\_ Thyroid

\_\_\_\_\_ Sarcoidosis

\_\_\_\_\_ Cancer (Type: \_\_\_\_\_)

\_\_\_\_\_ Hepatitis

\_\_\_\_\_ Astma

Any other health problems not listed: \_\_\_\_\_

## SKIN CARE

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

\_\_\_ Cleanser

\_\_\_ Sunscreen

\_\_\_ Moisturizer

\_\_\_ Vitamin C Creams

\_\_\_ Eye Cream

\_\_\_ Toner

\_\_\_ Scrub

\_\_\_ Mask

\_\_\_ Vitamin A Cream

\_\_\_ Glycolic Wash/Cleanser

\_\_\_ Soap

\_\_\_ Salicylic Wash/Cleanser

\_\_\_ Night Cream

\_\_\_ Alpha or Betahydroxy Cream

\_\_\_ Astringent

\_\_\_ Masque

\_\_\_ Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? \_\_\_\_\_

Massage preference: Firm \_\_\_\_\_ Light \_\_\_\_\_

Do you use Retin-A? \_\_\_\_\_

## SKIN ANALYSIS

\_\_\_ Unwanted hair

\_\_\_ Dry patches/Flaking

\_\_\_ Uneven Skin Tone

\_\_\_ White Spots (hypopigmentation)

\_\_\_ Enlarged pores

\_\_\_ Hard bumps under skin

\_\_\_ Acne

\_\_\_ Blackheads

\_\_\_ Upper lip lines

\_\_\_ Whiteheads

\_\_\_ Sun Spots

\_\_\_ Pimples

\_\_\_ Brown Spots (hyperpigmentation)

\_\_\_ Scarring

\_\_\_ Visible exposed blood vessels

\_\_\_ Sunburn Easily

\_\_\_ Clogged pores

\_\_\_ Blush Easily

\_\_\_ Excessive oiliness

\_\_\_ Redness

\_\_\_ Sun Damage

\_\_\_ Breakout

\_\_\_ Wrinkles

\_\_\_ Tightness

\_\_\_ Other \_\_\_\_\_

What is your skin type: Dry \_\_\_\_\_ Combination \_\_\_\_\_ Oily \_\_\_\_\_ Normal \_\_\_\_\_

Do you have any of the following chronic skin disorders:

\_\_\_ Psoriasis

\_\_\_ Eczema

\_\_\_ Fever Blisters

\_\_\_ Sun blisters

\_\_\_ Dermatitis

\_\_\_ Keloid Scarring

\_\_\_ Cold Sores

\_\_\_ Herpes Simplex/Blisters

**PAST TREATMENTS**

Have you ever had any of the following wrinkles fillers or implants:

- Collagen
- Sculptra
- Resylane
- Perlane
- Hylaform
- Juvaderm
- Silicone
- Radiance

Other: \_\_\_\_\_

Have you ever undergone any of the following treatments:

- Macrodermabrasion
- Acid Peel
- Accutane
- Microdermabrasion
- Cosmetic Surgery
- Lasers
- Botox

If yes to any, specify when and where \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently removing hair by any of the following methods?

- Waxing
- Tweezing
- "Nair" type products
- Electrolysis
- Laser Hair Removal

If yes to any, specify when and where and type of laser used \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR FEMALE CLIENTS ONLY**

Are you pregnant or trying to become pregnant? \_\_\_\_\_

Do you use oral contraceptives? \_\_\_\_\_

Do you use hormone replacement therapy? \_\_\_\_\_

Are you in or due for your menstrual period? \_\_\_\_\_

**FOR MALE CLIENTS ONLY**

Shaving system: wet \_\_\_\_\_ dry \_\_\_\_\_

Ingrown hairs? \_\_\_\_\_

Skin Breakout? \_\_\_\_\_

**LIFESTYLE**

Work Daily?\_\_\_\_\_

Do you smoke?\_\_\_\_\_how much?\_\_\_\_\_ how long?\_\_\_\_\_

Do you spend a lot of time outdoors?\_\_\_\_\_

Do you use a tanning bed often?\_\_\_\_\_

Do you use sunless tanning products?\_\_\_\_\_

Do you have any tattoos or permanent makeup? Locations\_\_\_\_\_

How much water do you consume per day?\_\_\_\_\_

How much coffee consumption per day?\_\_\_\_\_

How much soft drink consumption per day?\_\_\_\_\_

How much alcohol consumption per day?\_\_\_\_\_ week?\_\_\_\_\_ month?\_\_\_\_\_

Do you have a regular sleep pattern?\_\_\_\_\_

Please tell us your main concerns that brought you to our office today:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Patient's signature or Guardian

\_\_\_\_\_  
Witness/Consultant

\_\_\_\_\_  
Date