

Laser Skin Solutions

Hair & Vein Removal • Sun Spot Removal • Restylane • Botox • Skin Care • Tattoo Removal

Name _____ Today's Date ____/____/____
Last First Mo Day Yr

Address: _____ Birthdate ____/____/____
Mo Day Yr

City: _____ State: _____ ZIP: _____

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

Home Phone:() _____ Cell Phone:() _____ Work Phone:() _____

VIP E-mail _____ How did you hear about us? _____

Primary Care Physician _____ PCP Phone Number _____

Pharmacy _____ Phone Number _____

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

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

YES NO

Are you using any prescribed medications? List _____

Are you using any Herbal medications? List _____

Do you take oral anti-coagulant (blood thinning) medication? List _____

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

Are you pregnant or trying to become pregnant?

Do you use oral contraceptives?

Do you use hormone replacement therapy?

Do you smoke? How much? _____ How long? _____

Do you spend a lot of time outdoors or use a tanning bed often?

Do you have any tattoos or permanent makeup?

Please check any health problems, past or present:

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin cancer (Type: _____) | |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Collagen (Lupus, _____) | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Vasovagal Syncope | <input type="checkbox"/> PCOS | <input type="checkbox"/> Autoimmune (lupus, scleroderma) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other: _____ | | | <input type="checkbox"/> Hepatitis |
| | | | <input type="checkbox"/> Asthma |

Do you have any of the following chronic skin disorders?

- | | | | |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |

Other: _____

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- | | | | | |
|---|--|---|-------------------------------|---------------------------------|
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Visible exposed blood vessels | <input type="checkbox"/> Hard bumps under skin | | |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Clogged pores | <input type="checkbox"/> Blackheads /Whiteheads | | |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive oiliness | <input type="checkbox"/> Pimples | | |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring | | |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry patches | <input type="checkbox"/> Unwanted Hair | | |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown spots (Hyperpigmentation) | <input type="checkbox"/> White spots (Hypopigmentation) | | |
| What is your skin type: | <input type="checkbox"/> Dry | <input type="checkbox"/> Combination | <input type="checkbox"/> Oily | <input type="checkbox"/> Normal |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Cleanser _____ | <input type="checkbox"/> Soap _____ | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____ |
| <input type="checkbox"/> Eye cream _____ | <input type="checkbox"/> Astringent _____ | <input type="checkbox"/> Glycolic Wash/Cleanser |
| <input type="checkbox"/> Scrub _____ | <input type="checkbox"/> Sunscreen _____ | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream | <input type="checkbox"/> Vitamin C Creams | <input type="checkbox"/> Alpha or Betahydroxy Cream |

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

Please list _____

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

- | | | | | | | |
|-----------------------------------|---------------------------------------|----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Collagen | <input type="checkbox"/> Restylane | <input type="checkbox"/> Perlane | <input type="checkbox"/> Hylaform | <input type="checkbox"/> Juvaderm | <input type="checkbox"/> Silicone | <input type="checkbox"/> Radiesse |
| <input type="checkbox"/> Sculptra | <input type="checkbox"/> Other: _____ | | | | | |

* If so, when? _____ What area? _____ By whom? _____

Have you ever undergone any of the following treatments?

- | | |
|---|------------------------------|
| <input type="checkbox"/> Cosmetic Surgery | What area of the body? _____ |
| When and where was it done? _____ | |
| <input type="checkbox"/> Botox | What area of the face? _____ |
| When and where was it done? _____ | |

- | | | | | |
|------------------------------------|-----------------------------------|--|---------------------------------|------------------|
| <input type="checkbox"/> Acid Peel | <input type="checkbox"/> Accutane | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Lasers | Which one? _____ |
|------------------------------------|-----------------------------------|--|---------------------------------|------------------|

When and where was it done? _____

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

- | | | | | |
|---------------------------------|-----------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Tweezing | <input type="checkbox"/> "Nair" type products | <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Laser Hair Removal |
|---------------------------------|-----------------------------------|---|---------------------------------------|---|

* If so, when? _____ What area? _____ What type of laser? _____

I certify that the above information is correct to the best of my knowledge. _____
Patient's Signature

Laser Skin Solutions Notes:

