Laser M.D. Cosmetics

SKIN TYPING

Name _____ Date _____

Please answer the following questions by circling the number which best describes you. Your clinician will total the score during the consultation.

My ethnic origin is closest to: (check one)

I.	Very fair (Celtic and Scandinavian)	☐
II.	Fair-skinned Caucasians with light hair and light eyes	☐
III.	Pale-skinned Caucasians with dark hair and dark eyes	☐
IV.	Olive-skinned (Mediterranean, some Asian, some Hispanic)	☐
V.	Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	☐
VI.	Very dark skinned (Africans)	☐

My eye color is:

Light Blue	0
Blue / green	1
Green / gray / golden	2
Hazel / light brown	3
Brown	4

My natural hair color at age 18 was:

Red	0
Blonde	1
Light brown	2
Dark brown	3
Black	4

The color of my skin that is not normally exposed to the sun is:

Pink to reddish	0
Very pale	1
Pale with a beige tint	2
Light brown	3
Medium to dark brown	4
Dark brown-black	6

If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:

Burn, blister and peel	0
Burn, then when the burn resolves there is little or no color change	1
Burn, but then turns to tan in a few days	2
Get pink, but then turns to tan quickly	3
Just tan	4
Just gets darker	5
My skin color is so dark I can't tell	6

When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?

Longer than one month ago	0
Within the past month	1
Within the past two weeks	3
Within the past week	4

Total Score: ☐

If your score is:	Your skin type is:
0 – 3	I
4 – 7	II
8 – 11	III
12 – 15	IV
16 – 19	V
20 – 24	VI

Notes:

Form 4 / 7-10-08

Laser M.D. Cosmetics

Dear Patient: Our goal is to respond to all of our patient's needs and to provide the highest quality of care. In order to provide the information and service you desire on the health and appearance of your skin, we invite **you to complete the following questionnaire.**

Name: _____ Birth Date: ___/___/___ Date: _____

Address: _____ Sex: M / F

City: _____ State: _____ Zip Code: _____

Home: (____)_____ Work: (____)_____ Cell: (____)_____

Emergency Contact: _____ Telephone: (____)_____

Occupation:_____ e-mail address: _____

How did you hear about **Laser M.D. Cosmetics**:

_____

Best way to contact you: _____

Please put a check mark next to the procedures about which you would like to receive more information:

__Acne Treatment
__Botox ® (migraines & excessive sweating)
__Enhanced Skin Rejuvenation
__Collagen Augmentation
__Wrinkles
__Skin Toning/Pore Reduction
__Facial Redness
__Brown Spots
__Sun Damage
__Broken Capillaries
__Spider Veins
__Hair Removal
__Shaving Bumps/Ingrown Hair
__Hair Growth

Please put a check mark next to a past or current condition:

__Lupus or Auto-immune Deficiency
__Pregnant
__Bleeding Abnormalities
__Treatment with Accutane®in the last Six months
__Keloid or very thick scarring
__Psoriasis or Vertigo
__Pulmonary embolism/blood clot
__Leg ulcer or Phlebitis
__Blood thinning medication
__Rheumatoid Arthritis "Gold" Therapy
__Pacemaker
__Cosmetic Implants
__Diabetes
__Epilepsy
__Scars that turn White/Brown
__Dark Spots after pregnancy or skin injury
__HIV
__Hepatitis
__Waxing/Plucking/Electrolysis within last four weeks
__Transplant Anti-Rejection Drugs
__Chemical Peels, Dermabrasion Resurfacing or Face Lift
__Other

Do you have a history of Herpes Simplex, cold sores, or fever blisters? Yes / No
Do you have permanent cosmetic tattoo in the area to be lasered? Yes / No _____
Do you have, or have you used in the past, Collagen, Restylane™ or other dermal fillers?
Yes / No If yea, what area(s) were treated _____
Date of last treatment: _____
Have you had Botox®? Yes / No
Yes / No If yea, what area(s) were treated _____
Date of last treatment: _____
Do you now, or have you used bleaching cream? Yes / No When _____
Do you have any drug allergies? Yes / No Explain _____
Please list any medications or herbal supplements that you are currently taking:

_____

_____

_____ _____ _____ _____

Patient Signature **Date** **Reviewed by** **Date**