

Dermatique Laser and Skin

Patient Information

Patient Name _____ Date _____

Date of Birth _____ Age _____ Male _____ Female _____ Cell Phone# _____

Street Address _____ Phone# _____

City _____ State _____ Zip Code _____

Email Address _____ Occupation _____

Emergency Contact _____ Phone _____ Relation _____

How did you hear about us? _____

What procedures are you interested in? (Please check all that apply.)

- Botox – Dramatically reduces fine lines and wrinkles without surgery.
- Restylane or Radiesse – Long lasting injectable filler that helps to plump up lines.
- Juvederm, Cosmoplast or Cosmodern – Fill lips or small lines.
- Intense Pulse Light – Reduction of hyper-pigmentation such as freckles, age spots and redness.
- Aramis Laser – Non-invasive laser procedure that stimulates collagen production, reducing wrinkles, active acne, acne scarring, and improves tone and texture.
- Laser Vein Reduction – Non-invasive treatment to reduce purple-red facial and leg veins with no downtime.
- Laser Hair Reduction – A safe and highly effective treatment for the reduction for unwanted hair.
- Medical Microdermabrasion – An effective treatment to help reduce the appearance of acne, fine lines, and superficial pigmentation with No downtime.
- Custom Skin Care – A customized skin care regime designed for your specific skin from a licensed esthetician.
- Latisse Eyelash Serum – For Beautiful Longer, Thicker, Darker lashes!
- Facial – Customized for your skin.
- Chemical Peels – Want an even skin tone, lighter, glowing complexion.
- Acoustic Wave Therapy – Cellulite reduction.
- Sclerotherapy – A non-surgical vein treatment.
- Volumalift – A non-surgical face lift using Restylane. Price varies based on consultation.
- Portrait resurfacing – wrinkle reduction, scar reduction, decreases pore size, and treats precancerous lesions
- Mesotherapy – A localized non-surgical weight loss option. Body sculpting for those focal problem areas.

What are the cosmetic improvements/ expectations you have from this procedure?

Consultant Name _____ Photo Taken _____

Hippa Form Received _____ (Please Initial) Copy in chart _____

Gina Lesnik D.O. Medical Director and Treating Physician

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Skin History

Which of the following describes your skin? (check all that apply)

- Very oily skin
- Oily Skin
- Combination skin (oily T zone dry/normal cheeks)
- Flaky and/or dehydrated surface
- Normal
- Dry/Dehydrated surface
- Congested (Blackheads and/or Breakouts)
- Acne (severe comedo or cystic acne)

Please further describe your skin (check all that apply):

- | | | | |
|---|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Thick | <input type="checkbox"/> Thin | <input type="checkbox"/> Firm | <input type="checkbox"/> Mature |
| <input type="checkbox"/> Wrinkled | <input type="checkbox"/> Acne Scars | <input type="checkbox"/> Active Acne | <input type="checkbox"/> Blackheads |
| <input type="checkbox"/> Whiteheads | <input type="checkbox"/> Cysts | <input type="checkbox"/> Large Pores | <input type="checkbox"/> SunDamage |
| <input type="checkbox"/> Uneven/Blotchy | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Keratosis |
| <input type="checkbox"/> Patchy Dry areas | <input type="checkbox"/> Hyper Pigmentation | <input type="checkbox"/> Hypo Pigment | |

Describe your wrinkles Mild Moderate Severe

Do you wear contact lenses? _____ Are they in now? _____

List your current skin care products:

Cleanser _____ Moisturizer _____

Toner _____ Sun Block _____

Treatment/ Serum _____ Eye Cream _____

Are you currently using Retin-A, Renova, or Differin? _____ If so, how long? _____

Are you currently taking any of the following (Check all that apply)

- Advil/Motrin Aleve Excedrin Iron Pills Blood Thinner Anti Coagulant

Medical History

Please list all medications and/or vitamins you are taking: (Please explain their use)

Do you smoke? _____ How Long? _____

Have you ever used accutane? _____ When? _____

Have you recently used a topical or oral antibiotic? _____

Are you currently taking birth control or hormone replacement? _____

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Allergies _____

Do you have cold sores, herpes simplex, fever blisters; Yes/ No

- If yes, when was your last breakout? _____

General Medical conditions (Check all that apply)

- | | | | |
|--|------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bruising | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Herpes Simplex Rash | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Keloid Scars | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eczema | <input type="checkbox"/> Vitiligo | |

Are you pregnant or nursing? _____

Have you had any aesthetic procedures in the past? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Laser Resurfacing | <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Glycolic/AHA Peels |
| <input type="checkbox"/> Phenol Peel | <input type="checkbox"/> Pulsed Dyed Laser | <input type="checkbox"/> Collagen Injections |
| <input type="checkbox"/> Fat Transfer Injections | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> TCA Peel |
| <input type="checkbox"/> Laser Vein Removal | <input type="checkbox"/> Permanent Makeup | <input type="checkbox"/> Tattoo |
| <input type="checkbox"/> Liposuction | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Photo Facial | <input type="checkbox"/> Plastic Surgery _____ | |

List and Date any surgeries you've had: _____

What hair removal method do you use?

- Tweeze Depilatory Waxing Electrolysis Shave

If you are interested in Laser Hair Removal Please Fill Out the Remaining Pages.

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*****The following information will help our office to better understand and evaluate your skin type so your procedure can be tailored to your individual needs. Thank You for taking time to fill out this essential evaluation. Please circle one answer for each question. If unsure, circle the one with the lower number.

Genetic Disposition

<u>Score</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<u>Eye Color</u>	Lt Blue or Lt Green	Blue Green Hazel	Dk Blue Dk Green	Brown	Dk Brown/ Black
<u>Natural Hair Color</u>	Redhead	Blonde	Dk Blonde	Lt Brown	Dk Brown/ Black
<u>Natural Skin Tone</u>	Reddish	Very Pale	Pale with Beige Tones	Lt Brown	Dk Brown Black
Do you have Freckles on Un Exposed Skin?	Many	Several	Few	Incidental	None

Total score for your genetic disposition: _____

Do you have a heritage of darker pigmented skin such as African American, Hispanic, Indian, American Indian etc... Y / N _____

Reaction to Sun Exposure (Without use of sun protection)

<u>Score</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
<u>Skin reaction To extended Sun exposure</u>	Painful redness Blistering Peeling	Blistering Followed by Peeling	Burn Sometimes Peel	Rarely Burn	Never Burn
<u>To what degree Do you tan?</u>	Hardly or Not at all	Light Color & Freckles	Resonable Tan	Tan Easily	Turn Dark
<u>Do you turn Brown within Hours after the Sun exposure?</u>	Never	Seldom	Sometimes	Often	Always
<u>How does your Face react to the Sun?</u>	Very Sensitive	Sensitive	Normal	Very Resistant	Never Had a Problem

Total Score for Reaction to Sun Exposure: _____

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Tanning Habits

Score	0	1	2	3	4
When was the Last time you Exposed your Body to self tanning/ Tanning bed?	over 3 months ago	2-3 months ago	1-2 months ago	less than 1 month ago	less than 2 weeks ago
Have you Exposed the area To be treated To the sun?	Never	Hardly Ever	Sometimes	Often	Always

Total Score for Tanning Habits; _____

Summary

Add up totals for each section to better understand the personal evaluation of your skin type

Genetic Disposition Total _____
Sun Exposure Total _____
Tanning Habits Total _____

Skin Type Score _____

Fitzpatrick Skin Type Scale:

Skin Type Score	Fitzpatrick Type
0 – 7	I
8 – 16	II
17 – 25	III
26 – 30	IV
Over 30	V -VI

We send most correspondence through emails and may text appointment reminders.

I have answered the questions above to the best of my ability and I understand that all treatments are based on my answers and life habits.

Please note: Treatments may make you photo sensitive and I agree to wear sun block during laser treatments and chemical peels.

Client Signature: _____

Date: _____

Consultants Signature: _____ Date: _____