

Date: _____ Name: _____ First Middle Last DOB: ____/____/____ Gender **M** **F**

Phone: _____ Address: _____

Email: _____ Would you like to receive our email specials ? **Y** **N** (circle)

Tell us more about your concerns and goals for your treatments: _____

Preliminary Protocol For All Patients

How do you tan?

- Very Good
- Fairly Good
- Not Good at All
- Self Tan Method

How do you heal?

- Very Good
- Fairly Good
- Slow Healer
- Medical Control

Taking any type of drugs?

- Antibiotic
- Photosensitive
- Prescription Medication
- Other

Allergies/medical problems:

Existing Skin Condition/ ALL PATIENTS

- Acne
- Pitting
- Scarring
- Pock Marks
- Rash
- Eczema
- Spider Vein
- Freckles
- Light Pigmentation
- Dark Pigmentation
- other _____

Skin Type / ALL PATIENTS

- Very light Type 1
- Light Type 2
- Light to Medium Type 3
- Olive to brown Type 4
- Dark Brown Type 5
- Very dark Type 6

Skin Care Treatment Please Fill This Section Out

Have you ever seen a dermatologist or other physician for your skin? No Yes

Explain: _____

Have you previously had:

- Facials
- Chemical Peel
- Laser Resurfacing
- Facial Surgery

Explain: _____

Hypersensitivity and Skin Fragility

Have you ever had a skin allergy or sensitivity?

- Chemicals
- Cosmetics
- Fabrics
- Other: _____
- Notes: _____

Skin History

- Daily cleansing Yes No
- Moisturizer Yes No
- Eye creams Yes No
- Glycolic products Yes No
- Other: _____

Hair Reduction Please Fill Out This Section:

Previous Treatments for Hair Reduction:

- Electrology
- Shaving
- Waxing
- Sugaring
- Laser
- Tweezing
- Depilatories
- Epi-Lady
- Other

If other explain: _____

Desired Treatment Area(s) For Laser Hair Reduction:

- Abdomen (Linea)
- Abdomen (Total)
- Arms
- Arms Pits
- Back (Full)
- Back (Shoulders)
- Bikini (Total)
- Bikini Line
- Bikini (Labia / Anal)
- Breast (Areola)
- Chest (Pectoral)
- Chin
- Ears
- Eyebrows
- Feet (Toes)
- Face
- Hairline
- Hands (Fingers)
- Lip (Upper / Lower)
- Legs
- Neck (Front / Back)
- Nose (Top / Nostril)
- Private Areas
- Other _____

Vein/Lesion Removal Please Fill Out This Section:

Vein/ Lesion Type

- Skin Tag
- Freckles
- Spider Vein
- Cherry Hemangioma
- Vascular Lesion
- Other _____

Vein/ Lesion Location

- Back
- Face
- Legs
- Neck
- Head
- Chest
- Private Area
- Other _____

ALL PATIENTS

Treatment Time Frame?

- Very Soon
- Near Future
- Today if possible