Client Name: _____ Date: _____

Score: _____

		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut, Brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0-7 →	I
	8-16 →	II
____	17-25	III
	26-30	IV
	Over 30	V-VI

MEDICAL HISTORY, CONTINUED

		YES	NO
7.	Do you have **ANY** allergies to medications, foods, latex or other substances?	☐	☐
	Please List: _____		
8.	(For women) are you or could you be pregnant?	☐	☐
9.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____ _____	☐	☐
16.	In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: _____ _____	☐	☐
17.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
18.	Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
19.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
20.	Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
21.	Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	☐	☐

Signature: _____ Date: _____

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female ____ Male ____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

_____

_____

Please answer all of the following questions **YES** **NO**

1. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

   Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness.

   Please List: _____

   _____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition.

   Please List: _____

   _____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

   _____

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐

   Please List: _____

   _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?

   Please List: _____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? ☐ ☐