



Laser & Skin Care Consultation

Client Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Hm Phone: _____ Wk Phone _____ Cell Phone: _____ (Please circle preferred contact)

Email Address: _____ May we contact you? Phone, Address or Both? (Circle on)

Date of Birth: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

What concerns would you like to have addressed (Please Check All That Apply)

_____ Age Spots _____ Unwanted Hair. Indicate where: _____

_____ Facial/neck/chest redness _____ Veins. Indicate where: _____

_____ Acne Scars _____ Stretch Marks. Indicate where: _____

_____ Active Acne _____ Indicate where: _____

_____ Wrinkles and /or lines. _____ Indicate where: _____

_____ Stretch Marks. _____ Indicate where: _____

_____ Skin Care Products: A comprehensive selection of medical skin care products to complement your in-office procedure.

Please indicate any specific treatment or laser you are interested in

1. List any ONGOING HEALTH CONDITONS _____
2. Please list any current medications that you take, include any over the counter or supplements _____
3. Do you use any oral/topical antibiotic? If so, which one (s) and how long? _____
4. Do you have any drug allergies? If so, what drugs? _____
5. Do you take birth control? Hormone replacement. If so, which one and how long taken? _____
6. Are you currently using Accutane? If so, for how long? _____
7. Are you using Retin-A, Renova or Differin? If so, how long? _____
8. Do you or does anyone in you family have a history of seizures? _____
9. Are you sensitive/allergies to any of the following: _____ alpha-hydroxy acid _____ Retinol
 _____ RetinA _____ hydroquinone _____ preservatives _____ fragrances _____ sulfadrugs _____ aspirin _____ latex _____ wool

Client Consultation Continued, Pg.2

Name _____ DOB _____

Age _____ Gender _____ Ethnicity _____

10. Which of the following most closely describes your skin type?

- _____ Very fair, burns easily, never tans, freckles (typically red hair)
- _____ Light olive, sometimes burns (typically light to medium brown hair)
- _____ Light, burns fast then tans (typically blonde hair)
- _____ Medium olive, rarely burns
- _____ Dark brown, never burns

11. Which of the following best describes your skin type?

- _____ Very oily skin, large pores
- _____ Oily skin
- _____ Combination skin, oily n T-Zone, dry to normal cheeks
- _____ Normal skin
- _____ Dry Skin

12. Does your skin break out? _____ Almost always _____ Frequently _____ Rarely _____ Never

13. How would you describe your skin? _____ Sensitive _____ Resilient _____ Not Sure

14. Do you spend a lot of time outdoors? _____ Yes _____ No

15. Do you wear sunscreen? _____ Always _____ Sometimes _____ Never

16. Do you go to tanning booths? _____ Frequently _____ Sometime _____ Never _____

17. Have you or do you smoke? _____ Yes _____ NO

18. Have you had electrolysis, waxing or laser hair removal _____ Yes _____ No

If so, were you please with the results? _____

19. Have you ever had permanent make-up or (tattoo)? _____ Yes _____ No Body part _____

20. Have you ever had implants such as Artecoll, Restylane, Perlane, Juvederm, Radiesse, GoreTex or Silicone in the areas you are considering having treatment? _____ Yes _____ No

21. Are you currently having microdermabrasion, chemical peels, collagen injections or Botox? _____ Yes _____ No

If so, which and when was the last treatment? _____

22. ARE YOU PREGNANT? _____ Planning _____ Yes _____ No

23. Have you had any facial surgery? _____ Yes _____ No

24. Have you had any cosmetic peels? _____ Yes _____ No

If so, what? _____ Salon _____ Glycolic/AHA _____ Laser _____ TCA _____ Phenol

When? _____

25. Have you ever had laser vein removal? _____ Yes _____ No

Sclerotherapy? _____ Yes _____ No if yes, were you pleased with the results? _____ Yes _____ No

Client Consultation Continues, Pg.3

Name _____ DOB _____
Age _____ Gender _____ Ethnicity _____

25. Please list the brand names of products you currently use:

Cleanser	Soap
Toner	Moisturizer
Astringent	Scrub/Mask
Night cream	Eye cream
Sunscreen	Makeup
Other	Self-tanner
Hydroquinone	Retin A/Retinol

****Very Important** Please note these questions are to assess skin types for laser safety.**

(Required)

What is your ethnicity/nationality? _____

What is your Mother's ethnicity/nationality? _____ Father's ethnicity/nationality _____

Are you tan? _____ Do you tan artificially-tanning bed or spray on tan? _____

When is the last time you had significant amount of sun exposure? _____

Client Signature: _____ Date: _____