DERMACARE HR
Your Laser & Skin Care Clinic®
Refresh, Rejuvenate, Revive™

Client Medical History and Physical Assessment

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. ALL information is strictly confidential.

Client Name _____ Today's Date:_____ 20_____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

Home Address: _____City:_____ State: ___ Zip Code: _____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Occupation:_____ Email Address:_____

May we contact you: Mail Y ☐ N ☐ Email Y ☐ N ☐ Telephone Y ☐ N ☐
Note: We will not send spam or share your email with any other party.

Please circle preferred method for confirming your scheduled appointments:
Cell Phone **Home Phone**

Emergency Contact: _____ Phone: _____

Pharmacy Name/City & State_____

How did you hear of us?_____

Health issues and procedures/ products of interest to you (*Please check all that apply)*

- ☐ **Aesthetic Treatments : Chemical Peels /Microdermabrasion / Facials**
- ☐ **BOTOX Cosmetic TM (Botulinum Toxin Type A)**
- ☐ **Dermal Fillers**
- ☐ **Age/Sun Spots**
- ☐ **Acne Scars**
- ☐ **Active Acne**
- ☐ **Uneven Skin Pigmentation**
- ☐ **Facial / Neck/ Chest Redness**
- ☐ **Birthmarks**
- ☐ **Tattoo Removal / Reduction**
- ☐ **Black Ink Only** ☐ **Other Colors:**_____
- ☐ **Skin Rejuvenation**
- ☐ **Skin Care Products and Sunscreen Advice**
- ☐ **Unwanted Hair Reduction**
- ☐ **Spider Vein Treatment**
- ☐ **Wrinkles / Facial Lines**
- ☐ **Rough Skin**
- ☐ **Loose/ Sagging Skin**
- ☐ **Other:** _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

1) Considering my current age, when looking at my face in the mirror, I believe I look:
   Younger than True Age Older Than
   1 2 3 4 5
2) Considering the appearance of my wrinkles when looking in the mirror, I am:

Not Concerned Somewhat Concerned Very Concerned

1 2 3 4 5

Fitzpatrick Skin Type

Please list your ethnicity: _____ Mother's _____ Father's _____

Please circle your answers and write the number in the left hand column:

Score	Analysis	0	1	2	3	4
	What is the color of your Eyes?	Light Blue, Grey or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your Hair?	Sandy Red	Blond	Chestnut, Dark Blond	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 or not at all	Light Color 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
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
Total:	**Score**	**Fitzpatrick Skin Type**				

	0 – 7 I **8 -16 II** **17 – 25 III** **25 – 30 IV** **Over 30 V - VI**

Cosmetic/Aesthetic History:

1) How would you describe your skin? ☐ Sensitive ☐ Resilient ☐ Not sure
2) Describe your skin type:
   ☐ oily, large pores ☐ oily ☐ combination oily/dry ☐ normal ☐ dry ☐ very dry
3) Have you ever had any facial surgery performed? ☐ No ☐ Yes
   Type:_____
4) Have you ever had any type of Aesthetic Procedure? ☐ No ☐ Yes
   Type:_____
5) Have you ever had any complications with any aesthetic procedures/ treatments in the past?
   ☐ No ☐ Yes If so, what?_____
6) Have you ever had any of the following injectable procedures done?
   ☐ BOTOX ☐ Xeomin ☐ Juvederm ☐ Radiesse ☐ Belotero ☐ Other_____
7) Have you ever had laser hair removal? ☐ No ☐ Yes Type: _____
   _____
8) Have you ever had any type of laser or light based treatment (besides hair removal)?
   ☐ No ☐ Yes Type(s) _____
   _____
9) Have you ever had any RF (Radio Frequency) Treatments or other similar treatments?
   ☐ No ☐ Yes Type(s) _____
   _____
10) Do you sunbathe or go to tanning booths?
    ☐ Often ☐ Sometimes ☐ Never ☐ In the past
11) Do you use sunscreen? ☐ Always, SPF_____ ☐ Sometimes, SPF_____
    ☐ Yes, but not in past ☐ Never
12) Have you recently used any self tanning lotions or treatments? ☐ No ☐ Yes
    Type(s):_____
13) Have you had any *recent* tanning or sun exposure that changed the color of your skin?
    ☐ No ☐ Yes If so, explain_____
14) Do you have issues with hyper/ hypo pigmentation? (or marks after physical trauma)
    ☐ No ☐ Yes If so,
    explain_____

Medical and Family History

1) Are you currently under the care of a physician? ☐ No ☐ Yes For: _____
2) Are you currently under the care of a dermatologist? ☐ No ☐ Yes For: _____
3) Do you have any of the following medical conditions? (Please check all that apply):

☐ Cancer
☐ Herpes
☐ HIV/ Aids
☐ Seizure Disorder
☐ Thyroid Imbalance
☐ Blood Clotting
☐ Keloid Formation
☐ Immune Suppression
☐ Intraocular inflammation/Macular Edema
☐ Scleroderma or connective tissue disease
☐ Any Active/Chronic Infections
☐ Neuro-muscular disorder (ex. ALS, Myasthenia Gravis)
☐ Eye Pressure Problems (glaucoma)
☐ Diabetes
☐ Arthritis
☐ Skin disease/ Skin Lesions
☐ Hepatitis
☐ Acne
☐ Swallowing Problems
☐ Ongoing steroid treatment
☐ Neuropathy
☐ High blood Pressure
☐ History of cold sores
☐ Skin Cancer
☐ Hormone Imbalance
☐ Rosacea
☐ Asthma or emphysema
☐ Ongoing Chemotherapy
☐ Auto-immune disorders
☐ Metal Implants
☐ Facial Implants
☐ None

Please list any other health problems or medical conditions (not listed above):
_____
_____
_____

4) Does anyone in your family have a chronic skin condition? ☐ No ☐ Yes _____
5) Does anyone in your family have a chronic pigmentation disorder? ☐ No ☐ Yes_____
6) Any recent surgeries? _____
7) Have you been diagnosed (past/present) with depression, anxiety, panic attacks, or other psychiatric issues? ☐ Yes ☐ No

Social History:

1) Do you drink alcohol? ☐ No ☐ Yes, if so, on average how much/ often?_____
2) Do you smoke ☐ No ☐ Yes, if so, how much/ often?_____
3) Do you exercise? ☐ No ☐ Yes, occasionally ☐ Yes, regularly
4) Please describe your diet:
   ☐ A lot of room for improvement ☐ Some room for improvement ☐ Very Healthy
5) Are you pregnant? ☐ No ☐ Yes
6) Are you currently breastfeeding? ☐ No ☐ Yes
7) Are you planning to become pregnant? ☐ No ☐ Yes

Medication and Allergies

1) Do you have any allergies to ANY medications or supplements: ☐ No ☐ Yes

   Please list ALL and indicate type of reaction:

   _____

   _____

2) Do you have allergies to any of the following? If so please indicate your reaction.
   ☐ Latex ☐ Food (type):_____ ☐ Lidocaine
   ☐ Hydroquinone ☐ Alpha Hydroxy Acid ☐ Sulfa
   Reaction: _____

3) Please list ALL medications (including OTC) you are currently taking:

   ☐ Antibiotics ☐ Blood Thinners ☐ Birth Control ☐ Hormones
   ☐ Muscle Relaxers ☐ Aspirin ☐ NSAIDS (Motrin, Advil, Aleve)
   ☐ Coumadin ☐ Lovenox ☐ IOP (intraocular pressure) medication
   ☐ None
   ☐ Others (please list):

   _____

   _____

4) Have a pacemaker, internal defibrillator, or other implanted device? ☐ No ☐ Yes
5) Have you ever used Accutane? ☐ No ☐ Yes if so, when did you last use it? _____
6) What topical (external) medications or skin care products are you currently using?

   _____

   _____

7) Are you taking any strong anti-cholinergic medications (ex: Benadryl, Zantac, Amitriptyline)?
_____

8) What herbal (if any) supplements do you use regularly?
_____

9) Plans to have any surgeries in the next few years? If so, please explain_____
_____

Specific to Botox, Xeomin, Juvederm, Radiesse, Belotero, Chemical Peels, IPL, Dermasweep, and Image Skin Care Systems, Tretinoin, Hydroquinone

Do you have any of the following specific allergies or conditions? Please circle:

- ___Benzocaine/Lidocaine/Novocain/Tetrocaine?_____ **YES Not to my Knowledge**
- ___Hydroquinone or skin bleaching agents?_____ **YES Not to my Knowledge**
- Any Botulinum toxin (Botox®) product?_____ **YES Not to my Knowledge**
- Gram-positive bacterial proteins?_____ **YES Not to my Knowledge**
- Sodium Metabisulfite or Sulfites (found in foods & Rx preservatives)? **YES Not to my Knowledge**
- Weakness of Forehead muscles, trouble raising your eyebrows? **YES Not to my Knowledge**
- Drooping eyelids**?**_____ **YES Not to my Knowledge**
- Do you have a history of Erythema Ab Igne, (persistent skin rash caused by exposure to heat or infrared irritation?) **YES Not to my Knowledge**

If you circled "YES" to any of the above, please explain here:

_____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the health care providers at Dermacare of my current medical or health conditions and to update this history with any changes. I understand that my current medical is essential to determine and carry out any appropriate treatments or procedures.

Patient Signature_____ **Date**_____

Reviewed with Patient _____ **Date**_____