DERMA HEALTH
Laser & Skin Care Clinic

Client History

Today's Date_____

Office use: BD_____ **Aspire_____**

Name: _____ Date of Birth: _____Age: ____

Address: _____
City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ ◯Female ◯Male

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____ Occupation_____

Packages purchased are non-refundable but are transferable to another procedure or product within the clinic.

YOUR CONCERNS? **Skin Type:**

□ Sun Damage □ Redness □ Scars □ Acne □ Excess fat or cellulite □ Sagging skin □ Veins

□ Skin Lesions □ Wrinkles □ Skin texture □ Latisse □ Unwanted hair □ Preventative Medicine/Hormones

□ Hair Restoration □ Stem Cells □ PRP □ Female/Male Rejuvenation □ Breast Lift □ Melasma

□ Permanent cosmetics/tattoo □ Eyebrows □ Eyeliner □ Areola □ Lightening Other:_____

ALLERGIES: Check if you have ever had an allergic reaction to any of the following and describe what happened below.

□ **NONE**

Drugs_____

Foods (including eggs & milk): _____

Other allergies (including environmental): _____

Reaction: _____

List all medications, including supplements:

SKIN: Check all of the following that apply.

- □ History of skin cancer or pre-malignant moles: where/when_____
- □ Any keloid or hypertrophic scars - Location: _____
- □ Electrolysis, waxing, or laser hair removal □ Use of sunlamp/tanning bed/suntan outdoors
- □ Ever had a chemical peel? Type: □ Glycolic □ Laser □ TCA □ Phenol □ Jessner □ Salicylic □ Other
- □ Previous electrolysis, waxing, or laser hair reduction? _____ When? _____ Where? _____
- □ Previous laser vein reduction? Y N □ Sclerotherapy (injection)
- □ Other active skin disorders? Psoriasis, eczema, rashes, vitiligo, herpes simplex, acne, or other
  Describe: _____

FOREHEAD/EYES/EYEBROWS: Check all of the following that apply.

- □ Contact lenses □ Dry eyes □ Eye makeup sensitivities □ Scar
- □ Glaucoma □ Lasik /eye surgery □ Ptosis (eyelid droop) □ Uneven Brows
- □ Alopecia □ Pull out lashes/eyebrow compulsively (Trichotillomania)

Other eye disorders:_____

GENERAL MEDICAL: Check all of the following that apply.

- □ Diabetes
- □ High blood pressure
- □ Thyroid abnormalities
- □ Taken Accutane within the last 6 months
- □ History of Cancer
- □ Cold sores/fever blisters/herpes
- □ Asthma
- □ Birth control or hormone replacement
- □ Heart Palpitations, pacemaker or defibrillator
- □ Mitral valve prolapses or valve implants
- □ Polycystic Ovarian Syndrome (PCOS)
- □ Metal or implants in area to be treated
- □ History of Botulism immunization/military
- □ Recent use of anti-malaria medications
- □ Seizures
- □ Smoke? How long? _____
- □ Currently on blood thinners or anticoagulants such as Coumadin, aspirin, ibuprofen, alcohol, Vit. E, bruise easy or clotting disorder? _____
- □ Autoimmune or neuromuscular disorders - describe: _____
- □ Do you have a condition such as Hepatitis, HIV or undergoing treatment such as chemotherapy that could affect healing?_____
- □ Use of medications or herbs known to induce photosensitivity to light or use Retinal, Renova, Differin, Hydroquinone Fade cream: _____
- □ Current use of controlled substances - describe: _____

Please list any surgeries: _____

If you are currently under a physician's care for any condition, describe: _____

_____

Physician's Name: _____City: _____ Phone: _____

I have carefully reviewed this history and find it to be correct to the best of my knowledge.

Client Signature: _____Date: _____

Skin Type Worksheet

THIS INFORMATION IS REQUIRED FOR SKIN ANALYSIS

Your Ethnicity: _____

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 or Dark Blond	Dark Brown	Black
	What is the color of your skin in 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 for too long?	Painful redness and blistering followed by peeling	Blistering followed by peeling	Burn, sometimes followed by peeling	Rarely Burn	Never Burn
	To what degree do you turn brown?	Hardly or not at all	Light colored 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 a problem
	When did you last expose yourself to the sun, tanning bed, or tanning cream?	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 / Skin Type 0-7 / I 8-16 / II 17-25 / III 25-30 / IV Over 30 / V-VI					