



Name: _____
 Address: _____
 Phone #1: _____ Phone #2: _____
 Female Male Age: _____ Referred by: _____

Reason for consultation

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flushing of the skin |
| <input type="checkbox"/> Brown spots or sun damage | <input type="checkbox"/> Skin laxity |
| <input type="checkbox"/> Enlarged blood vessels | <input type="checkbox"/> Skin texture or scars |
| <input type="checkbox"/> Fine lines or wrinkles | <input type="checkbox"/> Unwanted hair |

Questions about skin

- How long have you been concerned about this area(s)? _____
- At what age did you notice this concern(s)? _____
- Are your present skin concern(s) getting more pronounced? Yes No
- Have you ever been treated for this concern(s)? Yes No
 If yes, when? _____
 What method? _____
- Are you currently taking medication for your skin's concern(s)? Yes No
 If yes, what is it? _____
- What topical skin medications or products are you currently taking?
 Retin-A® Hydroquinone or bleaching agent Other _____
- Have you ever had laser / IPL hair removal? Yes No
- Have you ever used the following hair removal methods in the past 6 weeks?
 shaving waxing electrolysis plucking/tweezing stringing depilatories
- Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No
- Have you ever had treatments for pigmented lesions? Yes No
- Do you form thick or raised scars (keloids) from cut or burns? Yes No
- Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? Yes No
- Have you had cold sores or fever blisters? Yes No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- | | |
|---|---|
| • Always burns, never tans <input type="checkbox"/> | • Rarely, burns, always tans <input type="checkbox"/> |
| • Always burns, sometimes tans <input type="checkbox"/> | • Brown, moderately pigmented skin <input type="checkbox"/> |
| • Sometimes burns, always tans <input type="checkbox"/> | • Black skin <input type="checkbox"/> |

1. When were you last exposed to the sun or tanning booth? _____
2. Do you use self tanners? Yes No
3. Are you planning a vacation in the sun? Yes No

Personal history:

1. Do you smoke? Yes No if yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? Yes No

Medical history:

1. Are you currently under the care of a physician? Yes No. If yes, for what:

2. Do you have any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Any active infection | <input type="checkbox"/> Heart disease | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> Skin cancer or moles |
| <input type="checkbox"/> Dark spots of pregnancy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hormone imbalance | <input type="checkbox"/> Vision deficits |
| <input type="checkbox"/> Other _____ | | |

3. Do you have allergies to any of the following? (check all that apply) medications latex
 food plants anesthesia other _____

4. Do you take any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Appetite depressants | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin or Ibuprofen | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Anti-coagulants | <input type="checkbox"/> Cortisone or steroids | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Hormone/contraceptives | <input type="checkbox"/> Other _____ |

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) Yes No
-

For female patients:

1. Are you pregnant or trying to become pregnant? Yes No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: _____ **Date:** _____



Skin Typing Matrix

Name: _____

Please answer the following questions by circling the number which best describes you. Your clinician will total your score during the consultation.

My ethnic origin is closest to:

Very fair (Celtic and Scandinavian)	<input type="checkbox"/>
Fair-skinned Caucasian with light hair and light eyes	<input type="checkbox"/>
Pale-skinned Caucasian with dark hair and dark eyes	<input type="checkbox"/>
Olive-skinned (Mediterranean, some Asian, some Hispanic)	<input type="checkbox"/>
Dark-skinned (Middle Eastern, Hispanic, Asians, some African)	<input type="checkbox"/>
Very dark-skinned (African)	<input type="checkbox"/>

My eye color is:

Light blue	0
Blue / Green	1
Green / Gray / Golden	2
Hazel / Light brown	3
Brown	4

My natural hair color at age 18 was:

Red	0
Blonde	1
Light brown	2
Dark brown	3
Black	4

The color of my skin that is not normally exposed to sun is:

Pink to reddish	0
Very Pale	1
Pale with a beige tan	2
Light brown	3
Medium to dark brown	4
Dark brown - black	5

If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:

Burn, blister and peel	0
Burn, then when burn resolves there is little or no color change	1
Burn, but then turns to tan in a few days	2
Get pink, but then turns to tan quickly	3
Just tan	4
Just gets darker	5
My skin color is so dark I can't tell	6

When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?

Longer than one month ago	0
Within the past month	1
Within the past two weeks	2
Within the past week	3

Total Score: _____

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

Additional skin response questions:

If you sustain an injury to your skin such as a cut, burn, or bruise, how long does it take to fully resolve without any hyperpigmentation? _____

What happens if you get an insect bite? _____