****

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking including over the counter, herbs or supplements;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any skin cancer to pre-cancerous lesions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any active skin allergies or skin diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous laser treatments in the last year? Yes\_\_\_\_\_\_ No \_\_\_\_\_ If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you or have you ever taken Accutane: Yes \_\_\_\_ No\_\_\_\_\_ Last date used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any cosmetic procedures such as: Chemical Peels\_\_, Microdermabrasion \_\_,

Botox \_\_\_, Fillers \_\_\_\_, Collagen Injections \_\_\_, Sclerotherapy \_\_\_, Micropigmentation \_\_\_, Permanent Makeup \_\_\_ Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2

Circle yes or no

Yes \_\_\_ No \_\_\_ 1) Do you have a history of cold sores? When was your last occurrence? \_\_\_\_\_\_\_\_\_\_\_\_

Yes \_\_\_ No \_\_\_ 2) Do you have any type of immune disorder? ex. Lupus, HIV, RA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes \_\_\_ No \_\_\_ 3) Do you have a history of keloid scarring or scars that haven’t healed smoothly?

Yes \_\_\_ No \_\_\_ 4) Do you have any skin disorders? (Psoriasis, Vitiligo, Skin Cancer ETC?

Yes \_\_\_ No \_\_\_ 5) Do you have or have you been diagnosed with any cancer with the past 5 years?

If so what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago were you diagnosed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been in remission? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes\_\_\_ No \_\_\_ 6) Are you diabetic or have a history of endocrine disorders?

Yes \_\_\_ No \_\_\_ 7) Are you currently pregnant or trying to become pregnant?

Yes \_\_\_ No\_\_\_ 8) Are you breastfeeding?

Yes \_\_\_ No \_\_\_ 9) Do you have polycystic ovarian disease, hirsutism, or thyroid disease?

Yes\_\_\_ No \_\_\_ 10) Do you have a heart or lung disease?

Yes\_\_\_ No \_\_\_ 11) do you have a pacemaker or a defibrillator?

Yes \_\_\_ No \_\_\_ 12) Do you have high blood pressure?

Yes\_\_\_ No \_\_\_ 13) Do you have any blood clotting problems or DVT? (Deep Venous Thrombosis)

Yes\_\_\_ No \_\_\_ 14) Do you take any medication that can cause Photo Sensitivity? (Such as antibiotics)

If so what are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes\_\_\_ No \_\_\_ 15) Do you have any tattoos in the area(s) where we are treating?

Yes\_\_\_ No \_\_\_ 16) Do you sunbathe or use tanning beds? If so how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes\_\_\_ No \_\_\_ 17) Does your skin remain discolored after healing from a wound?

Page 3

Which of the following best describes your skin type? CIRCLE ONE

1. Always burns, never tans
2. Mostly burns, rarely tans
3. Sometimes burns, then tans
4. Rarely burns, tans with ease
5. Never burns, always tans
6. Moderately pigmented, never burns

PLEASE CIRCLE YOUR GENETIC ORGIN: African, Asian, Caucasian, Hispanic, Mediterranean, Middle Eastern, Native American, OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE YOUR SKIN: CIRCLE ALL THAT APPLY

OILY DRY NORMAL COMBINATION

SENSETIVE FRECKLED AGE SPOTS MELASMA

WRINKLED SUN DAMAGE ROSACEA PSORIASIS

ECZEMA ACNE PRONE SCARRING WHITE/ BLACK HEADS

LARGE PORES SMALL PORES HYPOPIGMENTATION HYPERPIGMENTATION

What area would you like to treat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What services are you interested in or need more information about? Please circle

LASER HAIR REMOVAL LASER VEIN THERAPY ULTRASONIC MICRODERM CHEMICAL PEEL HOLLYWOOD PEEL TATTOO REMOVAL

MICRONEEDLING VAMPIRE SERVICES INFRARED SAUNA

BOTOX FILLERS PHOTOFACIAL

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures, I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from the treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof and am aware that no refunds will be given for services already provided.

To the best of my knowledge, the information I have provided is true. I understand that this information is confidential and will not be disclosed without my written consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient or Legal Guardians Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Licensed Professional Signature Date