

**SCORE 0-4 FOR EACH LINE THEN TOTAL AT THE BOTTOM:**

<b>SCORE</b>		<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
	What is the natural color of your hair?	Sandy red	Blonde	Chestnut, dark blond	Dark brown	Black
	What is the color of sun unexposed skin 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 are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of 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 or artificial sun treatments?	More than 3 months ago	2-3 month 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**

**CIRCLE YOUR SKIN TYPE BELOW BASED UPON SCORE ABOVE AND THE CHART BELOW** What is my skin type? 00-07 points = Skin type I, 08-16 points = Skin type II, 17-25 points = Skin type III, 25-30 points = Skin type IV 30-40 points = Skin type V & VI

<b>Skin Type</b>	<b>Skin Color</b>	<b>Hair Color</b>	<b>Eye Color</b>	<b>Characteristics</b>	<b>Ethnic Group</b>
I	Very fair	Blonde	Blue/green	Never tan, always burn	Europeans
II	Fair	Light brown, chestnut	Green/hazel	Sometimes tan, but usually burn	Europeans
III	Light olive	Chestnut	Hazel	Usually tan, but sometimes burn	Europeans
IV	Olive	Dark	Dark	Always tan, never burn (dark hair, dark eyes)	Asians, Indians, Latino
V	Dark brown	Brown/black	Brown/black	Never burn	Creoles, Latino
VI	Very dark	Black	Black	Never burn	African American Skin Tone

**INITIALS** \_\_\_\_\_

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## MEDICAL HISTORY- CIRCLE YES OR NO

- YES NO I agree not to use retin-A products on treated area 5 days before or after treatment
- YES NO I agree that I have not used glycolic on treatment area for past 24 hours
- YES NO I agree that I have not used retinol products on treatment area for 72 hours
- YES NO I agree that I have not taken Accutane in the past year
- YES NO I agree that I currently do not use hydrocortisone on treatment area
- YES NO I agree that I have not received radiation treatments/I do not have active cancer
- YES NO I agree that I have not had natural/artificial sun exposure to treatment area in past 3-4 weeks
- YES NO I agree to notify MD, PA, Nurse Practitioner and/or Esthetician of any concerns
- YES NO I agree to avoid sun exposure to treatment area for 3 - 4 weeks
- YES NO I agree that there may be crusting or shedding of skin
- YES NO I agree to not pick, peel or scratch the skin during the healing phase, if applicable
- YES NO I agree not to wax treatment area for 7 days prior to or after treatment
- YES NO I have an inflammatory skin condition (dermatitis, active acne, etc) or any skin condition
- YES NO I have a medical history of keloids, lived reticularis, erythema ab igne, vitiligo, psoriasis
- YES NO I have skin cancer or other cancer. Cancer Type/Location: \_\_\_\_\_
- YES NO I have used isotretinoin within the past year
- YES NO I have used self-tanners or tan enhancer caps within the past 3 - 4 weeks
- YES NO I have used herbal preparations (St Johns Wort, Ginkgo Biloba, etc) or aromatherapy (oils)
- YES NO I have had previous hair removal procedures on treatment area. If yes, when \_\_\_\_\_
- YES NO I have had vein surgery on requested treatment area
- YES NO I am having a lesion removed? If yes, when did you first see it \_\_\_\_\_
- YES NO Any observed change (color, size, texture, border) on the lesion to be treated? \_\_\_\_\_
- YES NO I have a tattoo and/or pigmented lesion on treatment area to be protected
- YES NO Any hair on the requested treatment area that should not be removed?
- YES NO I have had previous skin procedures on requested area (Botox, fillers, peels, etc. If yes, what and when? \_\_\_\_\_
- YES NO I am pregnant or nursing
- YES NO I bruise easily or have a history of excessive bleeding
- YES NO I have known allergies. If yes, list \_\_\_\_\_
- Initials \_\_\_\_\_

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DO YOU HAVE A HISTORY OF:

YES NO Neuromuscular disease such as Myasthenia Gravis, ALS or Multiple Sclerosis?

YES NO Have you had major dental work (ie dental implant/root canal/crown) in the past 2 weeks?

YES NO Herpes lesions around the mouth or in the genital area or Cold Sores/Fever Blisters

YES NO Diabetes and if yes, do you check your sugars YES NO What do your sugars run? \_\_\_\_\_

\*\* What Diabetes medicine(s) do you take? \_\_\_\_\_

YES NO \*\*Heart Disease, High Blood Pressure, High Cholesterol, Arrhythmia, Pacemaker, Clotting Disorder. If Yes, List Medications \_\_\_\_\_

YES NO \*\*Cancer and If yes, list medications \_\_\_\_\_

YES NO \*\*Epilepsy/Seizures and if yes, list medications \_\_\_\_\_

YES NO \*\*Mental Illness (depression, anxiety, hallucinations) and if yes, list medications \_\_\_\_\_

YES NO \*\* Infection and if yes, list antibiotics taking now \_\_\_\_\_

YES NO \*\*HIV/AIDS or Any Condition that has resulted in you being Immunocompromised or Immunosuppressed

YES NO \*\*Taking Antihistamine medications (Zyrtec, Allegra, Claritin, Benadryl)

YES NO \*\*Taking Antiinflammatory medications (Advil, Motrin, Naprosyn, Anaprox, Feldene, Voltaren, Lodine, Relafen, Daypro). If yes, when did you last take and how much?  
\_\_\_\_\_

YES NO \*\*Taking birth control pills

YES NO \*\*Taking Tegretol, Librium Neurontin, Accutane, Retin-A, Ambien

\*\*List any Medications you take that you have not yet listed  
\_\_\_\_\_

YES NO Do you smoke? If yes, how many years? \_\_\_\_ How much per day? \_\_\_\_\_

YES NO Do you drink alcohol? If yes, approximate # drinks per week \_\_\_\_\_

YES NO Have you consumed alcohol in the last 24 hours? If yes, how many drinks? \_\_\_\_\_

If Client is under 18 years of age, I hereby certify that I am the legal guardian of this client, that I am over 18 years of age and that I have read all of the above and certify that they are accurate for this client.

My signature certifies that I duly read and understand the content of this form and have accurately answered all questions. I hereby freely consent to Face and/or Body Procedures with or without the use of Laser or Radiofrequency.

Name Printed \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_