IMAGE PERFECT LASER

PHOTO REJUVENATION
Dermapen
PATIENT INFORMATION

Date:

Name:

Address:

City: State: Zip:

Home Phone: Business Phone:

Cell Phone: Email Address:

Date of Birth: Sex:

How did you hear about Image Perfect Laser?

PATIENT INFORMATION

Patient Skin Classification

Fitzpatrick Skin Type____________________(based on exposure to summer sun)

Type I	Always burn, never tan
Type II	Always burn, sometimes tan
Type III	Sometimes burn, always tan
Type IV	Never burn, always tan
Type V	Moderately pigmented (Hispanic, Asian, Mediterranean, Middle Eastern)
Type VI	Black

Fitzpatrick Wrinkle Class_________________

Class	Wrinkling
I	Fine wrinkles
II	Fine to moderate depth wrinkles, moderate number of lines
III	Fine to deep wrinkles, numerous lines, with or without redundant skin folds

Fitzpatrick Elastosis Score_____________

Score	Degree of Elastosis
1-3	Mild (fine textural changes with subtly accentuated skin lines)
4-6	Moderate (distinct popular elastosis, individual papules with yellow translucency under direct lighting, and dyschromia)
7-9	Severe (multipapular and confluent clastosis (thickened yellow and pa Approaching or consistent with cutis rhomboidalis)

Personal Medical History (Current Complaint)

What type of problem are you consulting for:

( ) Sun spots
( ) Wrinkles
( ) Distended blood vessels (red spots that may be spidery in appearance)
( ) Flushing of the skin
( ) Large pores
( ) Stretch marks
( ) Scars Location____

How many years have you noticed this problem? ________________________

At what age did your skin problem occur? ______________________________

Are your present skin problems becoming more pronounced? ( ) Yes ( ) No

Have you ever been treated for this problem? ( ) Yes ( ) No
If yes, when? ____
By what method? ____

Are you currently taking medication for your skin problem? ( ) Yes ( ) No
If yes, what medication?____

Are you pregnant, nursing or planning a pregnancy soon? ( ) Yes ( ) No

Do you have a history of keloid scarring? ( ) Yes ( ) No

Do you have a history of:

( ) Septicemia
( ) Herpes sores
( ) Easy bruisability
( ) Skin injury
( ) Heart disease
( ) Bleeding disorder
( ) Dark spots after pregnancy
( ) Diabetes

Have you had any allergic reaction to anesthesia? ( ) Yes ( ) No

Do you have any allergies, especially skin related? ( ) Yes ( ) No
If yes, please specify____

Do you have any allergies to medication? ( ) Yes ( ) No
If yes, please specify____

Are you taking any medication?

( ) Aspirin
( ) Hormones/ contraceptives
( ) Thyroid medication
( ) Sedatives
( ) Appetite depressants
( ) Anti-coagulants
( ) Cortisone
( ) Insulin
( ) Tranquilizers
( ) Other (please specify)__________

Patient Signature:___________________ **Date:**_________________