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Kristin Kenny, RN
399 Ocean Avenue
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Laser/eMatrix

To provide you with the most appropriate laser / RF treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PATIENT INFORMATION

Name (Last, first, middle initial)	Date
Street Address, City, ST, ZIP Code	Date of Birth
Email Address	Age
Emergency Contact Name	Contact Phone Number
Pharmacy Name & Address	Pharmacy Phone Number

How did you hear about Defy Nature?

Which of the following best describes your skin type? (Please Circle One Type Number)

I. Always burns, never tans
II. Always burns, sometime tans
III. Sometime burns, always tans
IV. Rarely burns, always tans
V. Brown, moderately pigmented kin
VI. Black skin

Do you regularly use tanning salons or sun bathe? How often?

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MEDICAL HISTORY

Are you currently under the care of a physician? **YES / NO**

If yes, for what:

Are you currently under the care of a dermatologist? **YES / NO**

If yes, for what:

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense of infrared irritation? **YES / NO**

Do you have the following medical conditions? (Please check all that apply)

Cancer		Skin Disease/Skin Lesions	
Diabetes		Seizure Disorder	
High Blood Pressure		Hepatitis	
Herpes		Hormone Imbalance	
Arthritis		Thyroid Imbalance	
Frequent Cold Sores		Blood Clotting Abnormalities	
HIV/AIDS		Any Active Infection	
Keloid Scarring			

Do you have any other health problems or medical conditions? (Please List)

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Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced)

Food	
Latex	
Aspirin	
Lidocaine	
Hydrocortisone	
Hyrdroquinone or Skin Bleaching Agents	

Others:

_____

MEDICATIONS

What oral medications are you presently taking? (Please check all that apply)

Birth Control Pills	
Hormones	

Others:

_____

Have you ever used Accutane? **YES / NO**
If yes, when did you last use it?

_____

Please list what topical medications or creams are you currently using? (Example: Retin-A®)

_____

What herbal supplements do you use regularly?

DEFY NATURE
Innovative Skincare

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HISTORY

Have you ever had laser hair removal? **YES / NO**

Have you used any of the following hair removal methods in the past six weeks?
(Please check all that apply)

Shaving	
Waxing	
Electrolysis	
Plucking	
Tweezing	
Stringing	
Depilatories	

Have you had any recent tanning or sun exposure that changed the color of your skin? **YES / NO**

Have you recently used any self-tanning lotions or treatments? **YES / NO**

Do you form thick or raised scars from cuts or burns? **YES / NO**

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin)? or marks after physical trauma? **YES / NO**

For Our Female Clients:

Are you pregnant or trying to become pregnant? **YES / NO**

Are you breastfeeding? **YES / NO**

Are you using contraception? **YES / NO**

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*Please note our office policy:

If you are unable to make your scheduled appointment and you do not notify us 24 hours prior to the appointment, a $25.00 fee will be included in your next procedure.

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____

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Fitzpatrick Skin Type Worksheet

Name: **Date:**

Score		0	1	2	3	4
	What is the color of your eyes?	Light Blue, Gray or Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
	What is your natural hair color?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your unexposed skin?	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 to long?	Painful Redness, Blistering, Peeling	Blistering Followed	Burns sometimes followed by Peeling	Rare Burns	Never had Burns
	To what degree do you turn Brown?	Hardly or Not at all	Light color 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 had a Problem
	When did you last expose yourself to the sun tanning bed or self-tanning creams?	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:	**Score**	**Fitzpatrick Skin Type:**
	0-7	I
	8-16	II
	17-25	III
Skin Type:	26-30	IV
	Over 30	V-VI

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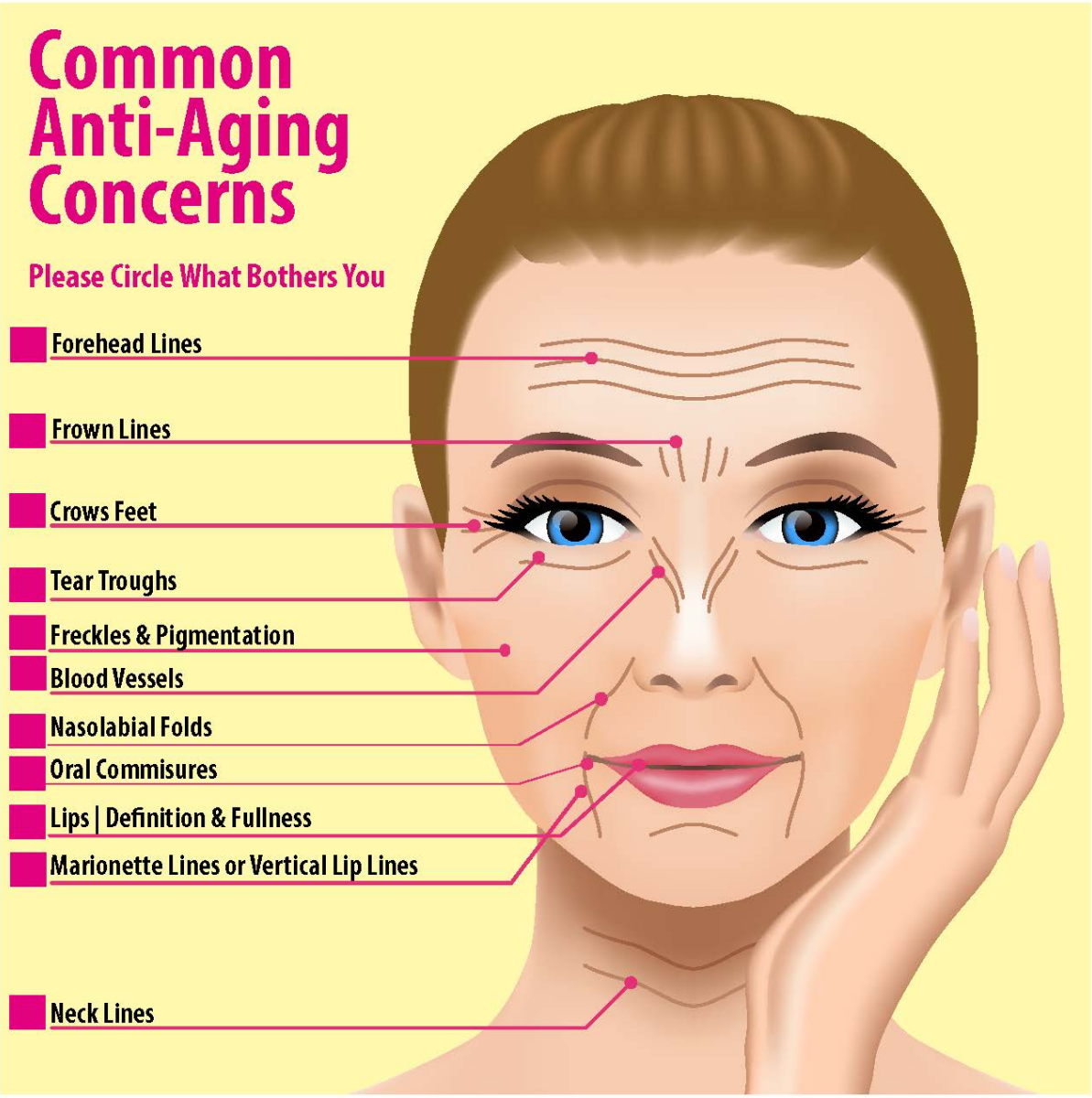

Skin Concerns		
Do you have any concerns with the appearance of your skin?	Yes	No
Do you want to learn more about at home skin care?	Yes	No
Do you have any issues with wrinkles or fine lines?	Yes	No
Do you have any issues with sun damage or age spots?	Yes	No
Do you have any issues with large pores or skin texture?	Yes	No
Do you have any concern with redness?	Yes	No