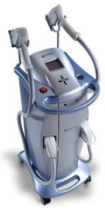
DERMATOLOGY ASSOCIATES of Central NJ

Syneron™ elōs eMax



LASER QUESTIONNAIRE FORM

Patient Name: _____ **Today's Date**: _____

Date of Birth: _____ Age: _____

Cell Phone: _____ Home Phone: _____

Main Concern that brought you into our office today for laser treatments:

- ☐ Acne
- ☐ Wrinkles
- ☐ Scarring
- ☐ Sun Spots
- ☐ Sun Damage
- ☐ Unwanted Hair
- ☐ Uneven Skin Tone
- ☐ Excessive Oiliness
- ☐ Brown Spots (Hyperpigmentation)
- ☐ Visible Exposed Blood vessels
- ☐ White Spots (Hypopigmentation
- ☐ Redness
- ☐ Rosacea

What areas of the body are you interested in treating?

- ☐ Face
- ☐ Neck
- ☐ Chest
- ☐ Arms
- ☐ Hands
- ☐ Legs
- ☐ Underarms
- ☐ Chin
- ☐ Axilla
- ☐ Groin
- ☐ Back

MEDICAL HISTORY: **Please be as honest as possible, this can affect the desired outcomes of your cosmetic procedures.**

NO / YES Are you currently using any prescribed medications?

If yes, please list all medications you are currently taking:

_____

_____

NO / YES Do you take any anti-coagulants (blood-thinning) medications? List: _____

NO / YES Are you using any herbal medications? List: _____

NO / YES Do you have any **allergies** to any cosmetic ingredients, medications, or foods? List:

_____

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

NO / YES Are you breast feeding currently?

NO / YES Do you use oral contraceptives? List: _____

NO / YES Do you use hormone replacement therapy? List: _____

NO / YES Do you smoke? How much: _____ How often: _____

NO / YES Do you use tanning beds? How much: _____ **Last tan**?_____

NO / YES Do you have any tattoos or permanent makeup? List: _____

NO / YES Have you ever used Gold Therapy? When: _____

NO / YES Have you ever had skin cancer? List: _____

NO / YES Do you exercise? Indoors or Outdoors (Circle one)

NO / YES Have you ever been diagnosed with Hepatitis A, B or C?

NO / YES Do you go spray tanning? Last spray tan date: _____

NO / YES Do you have a history of cancer? List: _____

NO / YES Do you have a history of diabetes? Last HbA1C: _____

NO / YES Do you have a history of autoimmune diseases? (Lupus, Scleroderma, etc) List: _____

NO / YES Are you taking any immunosuppressive medications? List: _____

NO / YES Do you have a history of keloid scarring?

NO / YES Do you have a pacemaker?

NO / YES Have you ever taken Accutane or Isotretinoin? Date of last dose: _____

NO / YES Have you ever used Tretinoin or Retinol products? Date of last dose: _____

NO / YES Have you taken any NSAIDS? Date of last dose: _____

NO / YES Are you using any topical creams or oral antibiotics for acne, skin cancer, anti-aging, or hyperpigmentation? List: _____

When was *first day* of your *last menstrual cycle*? _____

MEDICATIONS: Have you taken any of the following? Please note: These are not all, but some, of the most common list of medications that may cause increased photosensitivity and/or hyperpigmentation.

- **Isotretinoin (Accutane)**
- **Tretinoin (Retin-A, Atralin, Ziana, Tazorac)**
- Cyclophosphamide
- Chlorambucil
- Fluorouacil
- Methotrexate
- Procarbazine
- Amitriptyline
- Clomipramine
- Doxepin
- Isocarboxazid
- Phenelzine
- Protriptyline
- Trazadone
- Trimipramine
- Carbamazepine
- Cyclobenzaprine
- Diazepam
- Phenobarbitol
- Diphenhydramine
- Terfenadine
- Tripelennamine
- Captopril
- Dilitazem
- Methyldopa
- Minoxidil
- Nifedipine
- **Ciprofloxacin**
- **Dapsone**
- **Doxycycline**
- **Griseafulvin**
- **Ketoconazole**
- **Minocycline**
- Ofloxacin
- **Sulfa Drugs (Bactrim, Tetracycline)**
- Chloroquine
- Chlorpromazine
- Haloperidol
- Amiodarone
- Atenolol
- Captopril
- Diltiazem
- Nifedipine
- Propranolol
- Quinidine
- Verapamil
- Benzthiazide
- Chlorothiazide
- Furosemide
- Hydrochlorothiazide
- Amiloride

- ☐ Acetazolamide
- ☐ Quinethazone
- ☐ Chloropromaide
- ☐ Glipizide
- ☐ Tolbutamide
- ☐ Diclofenac
- ☐ Fenoprofen
- ☐ Indomethacin
- ☐ Ketoprofen
- ☐ Naproxen
- ☐ Phenylbutazone
- ☐ Bergamot Oil
- ☐ Oral Contraceptive
- ☐ Gold Salts
- ☐ St. John's Wart

If so, please explain:

Drug name: _____ what dosage: _____

Date of last dose: _____

Do you have any of the following?

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Acne
- ☐ Cold sores
- ☐ Rosacea
- ☐ Seizures/Epilepsy
- ☐ Vasovagal syncope
- ☐ PCOS
- ☐ Psoriasis
- ☐ Cystic Acne
- ☐ Vitiligo
- ☐ Melasma
- ☐ Herpes Simplex

COSMETIC INFORMATION:

Please check the products you currently use and list the BRAND NAMES:

- ☐ Cleanser: _____
- ☐ Moisturizer: _____
- ☐ Sunscreen: _____
- ☐ Exfoliant: _____
- ☐ Eye Cream: _____
- ☐ Vitamin A: _____
- ☐ Vitamin C: _____
- ☐ Other: _____

Have you ever had any of the following wrinkle fillers or facial implants:

- ☐ Collagen
- ☐ Restylane
- ☐ Hylaform
- ☐ Juvaderm
- ☐ Silicone
- ☐ Radiesse
- ☐ Perlane
- ☐ Sculptra
- ☐ Other: _____

If so, when? _____ What area? _____ By whom? _____

Have you ever undergone any of the following treatments?

- ☐ **Cosmetic Surgery.** Please list: What area of the body? _____ When and where was it done? _____
- ☐ **Botox**. Please list: What area of the face? _____ When and where was it done? _____
- ☐ **Laser Treatment**. Please list: What are of the face? _____ When and where was it done? _____
- ☐ **Chemical peel** ☐ **Accutane** ☐ **Microdermabrasion**

  Please list: When and where was it done? _____

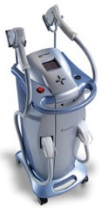
Do you have any **upcoming events** in the next 7 days after your treatment? If so, when: _____

Please sign and date this form stating all the information you have provided is true and accurate.

Printed Name: _____ Signature: _____ Date: _____

DERMATOLOGY ASSOCIATES of Central NJ

Syneron elōs eMax



LASER SKIN TYPING FORM

Patient Name: _____ Today's Date: _____

Date of Birth: _____

GENETIC DISPOSITION: Please circle the appropriate box for each question.

Score	0	1	2	3	4
Eye Color?	Light blue, green	Gray	Blue	Dark brown	Brown/black
Natural Hair Color?	Sandy red	Blonde	Chestnut/dark blonde	Dark brown	Black
Skin Color?	Reddish	Very pale	Pale	Light brown	Dark brown
Freckles?	Many	Several	Few	Incidental	None

REACTION TO SUN EXPOSURE: Please circle the appropriate box for each question.

Score	0	1	2	3	4
What happens when you are over exposed to the sun?	Redness/blistering /peels	Blistering/ peels	Burns sometimes/peels	Rarely burns	Never burns
What degree does your skin turn brown?	Hardly/not at all	Light color tan	Medium tan	Tans easily	Turns brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	No problem

TANNING HABITS: Please circle the appropriate box for each question.

Score	0	1	2	3	4
When was your last exposure to the sun and/or tanning beds for more than 30 minutes at a time?	More than 3 months	2-3 months	1-2 months	Less than 1 month	Less than 2 weeks
Was the treatment area exposed?	Never	Hardly ever	Sometimes	Often	Always

HERITAGE: Please circle the appropriate box for each question.

Score	0	(+5)
Is your mother African American or of East Indian Descent?	No	Yes
Is your father African American or of East Indian Descent	No	Yes
Are your grandparents African American or of east indian descent?	No	Yes (add points if no points added for parent)
Are you latin American, Asian-pacific islander, Mediterranean, or Native American?	No	Yes

SUMMARY: FOR OFFICE USE ONLY.

Total for genetic disposition =	
Total for reaction to sun exposure =	
Total for tanning habits =	
Total for heritage =	
Skin type score =	

SKIN TYPE: FOR OFFICE USE ONLY.

0-8	I
9-16	II
17-24	III
28-30	IV
31-34	V
35+	VI