



PATIENT IN-TAKE FORM

Name: _____ **Date:** _____
How did you hear about us? (Whom may we thank for your referral?) _____
Cultural Heritage: _____ **Family History of Rosacea? Y / N** _____
E-mail Address at which we may contact you: _____
Birth date: _____ **Occupation:** _____ **Employer:** _____
Home Address: Street: _____ **City:** _____
State: _____ **Zip:** _____ **Preferred Phone for Us to Contact:** _____
Emergency Contact Name: _____ **Phone:** _____
Dermatologist Name: _____ **Phone:** _____

Height: _____ **Weight:** _____ Have you had recent weight loss Y/N or weight gain Y/N? If so, how much? _____
Past Medical History: Have you had any problems with: Easy Bruising: Y / N Excessive Bleeding: Y / N
 Heart: Y / N Lungs: Y / N Kidneys: Y / N Skin: Y / N Blood Clots: Y / N
 Cancer: Y / N Joints: Y / N Liver: Y / N Nervous System: Y / N Stomach/ Intestines: Y / N
 Diabetes: Y / N Thyroid: Y / N

If you answered yes to any of the above OR have any other medical problems, please describe here: _____

What surgeries have you had: _____
 Have you ever had a complication from surgery? _____

Medications you are taking: _____
 Are you taking aspirin or any aspirin-containing medications, vitamin E, or fish oil? _____

Allergies to medications or latex: _____
Hormonal: Do/did you naturally have regular monthly periods? Y / N Date of last period: _____ Birth Control Method: _____
 Any difficulty getting pregnant? _____ Are you taking hormone replacement? Y / N What type? _____

Social: circle one: Married / Single / Divorced / Committed Relationship If divorced, date of divorce: _____
 Children: Boys: # ___ / Ages _____ Girls: # ___ / Ages _____

Skin Care Brands Used: Cleanser: _____ Retinoid: _____ Moisturizer: _____
 Exfoliant: _____ Sunscreen: _____ Eye Cream: _____ Serum (Vit. C/E): _____
 Cosmetics Used: _____

	History:				History:		
	Yes	No	Date		Yes	No	Date
Fillers (Restylane, etc.)				Electrolysis			
Accutane, last 6 months				Botox			
Hydroquinone, last 12 months				Retinoid Use			
Tattoos/Permanent Make-up				Microdermabrasion			
Cold Sores/Herpes			Last outbreak	Chemical Peels			
Vitiligo (patches of light colored skin)				Implants/Surgeries/Scars in Treatment Area			
Previous Laser Treatments				History of Keloid Scars			

Lifestyle:		Y / N	Quantities:	Diet:	Quantities:
Sun Exposure	Y / N	Circle one	Frequent / Occasional / Rare	Meat	Svgs/wk Red _____ Poultry _____ Fish _____
Sunburns	Y / N	# bad burns ever (blistering) _____			Are your meats hormone-free? Y/N
UVA+UVB Screen	Y / N	# SPF used Daily _____ Extended Sun _____		Milk	cow / soy / rice Cup/day _____ Organic? Y / N
Self-Tanner Use	Y / N	Most recent date _____		Beverages	Water _____ oz/day Caffeine _____ c/day
2 nd Hand Smoke	Y / N	Daily _____ Weekly _____ Monthly _____			Sweetened _____ c/day Diet _____ c/day
Smoking Now	Y / N	Packs / day _____ # Years _____		Fruits/Veggies	Fruit c/d _____ Veggies c/d _____
Ever	Y / N	Packs/d _____ #Yrs _____ When quit? _____		Whole grains	Servings per day _____
Alcohol	Y / N	Drinks / week _____ Type _____		Refined flours/sugars	Servings per day _____
Exercise	Y / N	Aerobic _____ /wk. Weights _____ /wk.		Artificial Sweeteners	Y / N
High stress?	Y / N	Job? _____ Family? _____ Finances? _____		Processed food	Servings / day _____
Regular Relaxation	Y / N	Type _____		Trans-fats	Servings / day _____

X _____
Signature

Date

9/27/11

Cosmetic Interest Questionnaire

Please complete **both front and back sides** of this sheet.

Patient Name:	Date:
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General appearance or products of interest to you (please check all that apply).

<input type="checkbox"/> Skin care products <input type="checkbox"/> Skin care advice <input type="checkbox"/> Nutrition for skin wellness <input type="checkbox"/> Brown spots on face, neck, chest, or hands (circle) <input type="checkbox"/> Blotchiness on neck <input type="checkbox"/> Facial veins <input type="checkbox"/> Rosacea <input type="checkbox"/> Spider veins <input type="checkbox"/> Strawberry angiomas <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Loose, sagging, crepe-like skin on face, neck, arms, or abdomen (circle) <input type="checkbox"/> Old-looking hands <input type="checkbox"/> Black- or White-heads <input type="checkbox"/> Pimples <input type="checkbox"/> Cystic acne <input type="checkbox"/> Acne Scars <input type="checkbox"/> Large pores/Fine lines <input type="checkbox"/> Uneven texture <input type="checkbox"/> Dull Skin <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Hair on lip <input type="checkbox"/> Hair on cheeks <input type="checkbox"/> Sideburns <input type="checkbox"/> Chin hair <input type="checkbox"/> Neck hair <input type="checkbox"/> Unibrow <input type="checkbox"/> Chest hair <input type="checkbox"/> Underarm hair <input type="checkbox"/> Bikini hair <input type="checkbox"/> Lower Leg hair <input type="checkbox"/> Upper Leg Hair <input type="checkbox"/> _____ <input type="checkbox"/> Eyelash length, fullness, or thickness <input type="checkbox"/> Tinting of lashes, brows, mustache, beard	<input type="checkbox"/> BOTOX® (circle which): frown line, forehead lines, crow's feet <input type="checkbox"/> Flat cheeks <input type="checkbox"/> Facial creases (circle which): nose-to-mouth; below mouth; around lips <input type="checkbox"/> Thin lips <input type="checkbox"/> Chemical peels <input type="checkbox"/> _____ <input type="checkbox"/> Teeth whitening <input type="checkbox"/> Teeth straightening <input type="checkbox"/> Veneers
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Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.
 When looking at your face in the mirror, do you believe you look younger, the same as, or older than your true age?

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, what is your level of concern about the appearance of your wrinkles?

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> A friend or family member	<i>Name:</i>
<input type="checkbox"/> Internet; Facebook; LinkedIn	
<input type="checkbox"/> The Timeless Laser & Skin Care website	
<input type="checkbox"/> Mimi Advertisement	
<input type="checkbox"/> Plain Dealer Expert Exchange	
<input type="checkbox"/> Cleveland.com	
<input type="checkbox"/> Benefit Auction	<i>Name of benefit:</i>

<input type="checkbox"/> Approval to contact you.	<i>Best phone number to reach you:</i>
<input type="checkbox"/> Approval to send you our monthly e-newsletter with information about nutrition, skin care, and promotions	<i>Email address:</i>

Patient Signature:	Date:
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Fitzpatrick Skin Type Form

Score	0	1	2	3	4
What color are your eyes?	light blue, gray, green	blue, gray or green	blue	dark brown	brownish black
What is the natural color of your hair?	sandy red	blond	chestnut/ dark blond	dark brown	black
What is the color of your skin (non-exposed areas)?	reddish	very pale	pale with beige tint	light brown	dark brown
Do you have freckles on unexposed areas?	many	several	few	incidental	none

⇐ **Total score for Genetic Disposition**

Score	0	1	2	3	4
What happens when you stay too long in the sun?	painful redness, blistering, peeling	blistering, followed by peeling	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 easy	turn dark brown quickly
Do you turn brown within several hours of exposure?	never	seldom	sometimes	often	always
How does your face react to the sun?	very sensitive	sensitive	normal	very resistant	never had a problem

⇐ **Total score for reaction to sun exposure**

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream?)	more than 3 months ago	2-3 months ago	1-2 months ago	less than a month ago	less than 2 weeks ago
Did you expose the area to be treated to the sun?	never	hardly ever	sometimes	often	always

⇐ **Total score for tanning habits**

Summary

	⇐ Total score for genetic disposition
	⇐ Total score for reaction to sun exposure
	⇐ Total score for tanning habits
	⇐ Total skin type score

Your Fitzpatrick Skin Type

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
over 30	V