Chesapeake CosMedic Center

Prince Frederick, MD 20678
410-535-2811

PERSONAL PROFILE AND HEALTH HISTORY

NAME: ____Date of Service: _______________

Date of Birth: _____/_____/_____ Age: __________ Gender: Male Female

Address: ____

City/State/Zip: ____

Contact Information:	Order of contact:
Home number: __________________________________	1st, 2nd, 3rd, 4th
Work number: __________________________________	1st, 2nd, 3rd, 4th
Cell number: __________________________________	1st, 2nd, 3rd, 4th
e-mail address: __________________________________	1st, 2nd, 3rd, 4th

Occupation: ____

How did you hear about us? ____

What treatment(s) are you interested in? Check all that apply

____Facial Rejuvenation ____Pigmented lesions
____Hair Removal ____Spider Veins

What cosmetic improvements would you like to see? ____

____

Name of your family doctor: ___________________________________Telephone number: __________

Medical History: Please check all that apply

___Acne	___High Blood Pressure	___Port wine stain
___Bleeding disorders	___Hirsutism	___Psoriasis
___Burns/skin grafts	___Hormone Replacement	___Seizure disorder
___Diabetes	___Implants	___Shingles
___Eczema	___Kaposi's sarcoma	___Skin cancer
___Epidermolysis Bullosa	___Keloid scars	___Tattoos
___Heart disease	___Lupus erythematosus	___Thyroid disease
___Herpes	___Permanent make-up	___Vitiligo
	___Polycystic ovary disease	___Other_________________________

Do you currently or have you ever used tobacco? Yes No

If yes, type of tobacco: cigarettes cigar pipe chew

Amount: ___________________________________

For how long: ___________________________________

If quit, when?: ___________________________________

NAME:____Date of Birth: _____/_____/_____

Please **list ALL medications** to include over the counter, vitamins, herbals, and supplements.

____
____
____
____
____

Please **list ALL allergies** to include latex and your reaction:

____
____

Please answer the following questions.

1. Have you used Accutane® in the last 6 months? Yes No
   a. If yes, when: ____
2. Do you have any active skin diseases in the area to be treated? Yes No
3. Do you have any infections such as cold sores or fever blisters in the area to be treated? Yes No
4. Do you have any skin allergies? Yes No
5. Are you currently using glycolic acid? Yes No
6. Are you currently using Retinoid products (Retin-A®, Renova®, Differin®, Tazorac®, Avage®)? Yes No
7. Have you had a chemical peel for facial within the last week? Yes No
8. Do you have regular collagen, Botox®, or other dermal filler injections? Yes No
9. Have you had any permanent cosmetic tattooing in the area to be treated? Yes No
10. Do you have any metal or other implants? Yes No
11. Do you wear contact lenses? Yes No
12. Have you recently had facial surgery? Yes No
13. Have you had previous laser treatment, resurfacing or other skin treatments to the area to be treated? Yes No
14. Are there any moles with hair in the area to be treated? Yes No
15. Are you currently using or have used a tanning cream or a tanning bed within the past 6 weeks? Yes No
16. Have you been exposed to the sun within the last 4-6 weeks? Yes No
17. Do you currently use dipilatories or waxing? Yes No
18. Are you currently using any skin care products? Yes No
    a. If yes, please list:
    ____
    ____

I confirm that the answers to the questionnaire are true and correct. I also confirm that my questions have been answered to my satisfaction.

_______________________________________ _______________________

Client Signature Date

_______________________________________ _______________________

Consultant Signature Date

_______________________________________ _______________________

Physician Signature Date

Chesapeake CosMedic Center

Fitzpatrick Skin Typing Test

NAME: ____ **DOB:** ____/____/_____

Thank you for choosing the Chesapeake CosMedic Center for your beauty care needs.

One of the important parameters for the success of your treatment is the correct typing of your skin.

Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your clinical are:

• Genetic disposition - Skin Types I to III should add one level when you have blood relatives with darker skin type IV or higher.
• Reaction to sun exposure and tanning habits

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc.. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color

To help us determine your skin type and treat you the right way, please take the test below by circling the response that most closely fits your description.

Genetic Disposition

___African American ___Caucasian ___Mediterranean ___Native American
___Asian ___Hispanic ___Middle Eastern ___Other ___________________

Genetic Disposition					
Score	0	1	2	3	4
What is the color of 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: _____					

NAME: ____ **DOB:** ____/____/_____

Reaction to Sun Exposure					
Score	0	1	2	3	4
What happens when you stay in the sun too long?	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 after sun 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: _____					

Tanning Habits					
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: _____					

Add up the total scores for each of the three sections for your Skin Type Score.

Genetic Disposition Score: _______________

Reaction to Sun Exposure Score: _______________

Tanning Habits Score: _______________

TOTAL SCORE: _______________

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