

## CLIENT QUESTIONNAIRE - PhotoDerm

Name: \_\_\_\_\_

### **MEDICAL INFORMATION:**

Do any of the following pertain to you?

NO    YES    DATE

_____	_____	_____	Accutane
_____	_____	_____	Allergies
_____	_____	_____	Autoimmune disease, HIV, Lupus, Hepatitis
_____	_____	_____	Birth Control Pills, Hormones
_____	_____	_____	Diabetes
_____	_____	_____	Eczema
_____	_____	_____	Glycolic Treatments
_____	_____	_____	Herpes, Cold Sores, Fever Blisters
_____	_____	_____	Irregular, Pigmented Moles or Growths
_____	_____	_____	Keloids, Pigmented Scars
_____	_____	_____	Migraine Headaches
_____	_____	_____	Pregnancy, Breast Feeding
_____	_____	_____	Retin A, Renova
_____	_____	_____	Recent sunburn (area being treated)
_____	_____	_____	Warts (area being treated)
_____	_____	_____	Smoke
_____	_____	_____	Any condition not listed: _____
_____	_____	_____	Currently under the care of a physician? _____
_____	_____	_____	Currently taking any medication? _____
_____	_____	_____	Previous laser procedures, chemical peel, dermabrasion or Microdermabrasion?

In doing PhotoDerm, my interest is primarily for (skin rejuvenation, acne, hyper pigmentation, roseacea, etc.): \_\_\_\_\_

Specific areas of concern: (eyes, mouth, forehead, nose, chest) \_\_\_\_\_