Skin Analysis

NAME: _____ DATE: _____

LITTLE MOUNTAIN LASER

Please check all the areas that you are considering for treatment:

___ Face ___ Neck ___ Arms ___ Legs ___ Bikini Line
___ Abdomen ___ Armpits ___ Chest ___ Genitals ___ Back
___ Hands/Feet ___ Buttocks

Please check the conditions you would like treated:

___ Hair/Sun Damage ___ Wrinkles ___ Dull Skin
___ Spider Veins ___ Acne ___ Dark spots / age spots
___ Cherry Spots ___ Facial Veins

Have you ever had:

___ Laser ___ Chemical Peel ___ Electrolysis ___ Botox / Restylane
___ Microdermabrasion ___ Permanent Makeup ___ Tatoos in areas to be treated

When?_____

Have you used any of these in the last month : Renova, Tazorac, Retin A, Alpha Hydroxy or Glycolic acids?

___ No ___ Yes

Have you used Accutane or had radiation therapy?

___ No ___ Yes

Are you currently taking any of the following? Tetracycline, Bactrim, Hydrochlorothiazide, St. Johns Wort, Antibiotics (oral or topical), or any other medication that may make you sensitive to the sun?

___ No ___ Yes – type/location: _____

Medication allergies: _____

In the last 6 weeks have you done any of the following?

___ Tweezing ___ Waxing ___ Bleaching ___ Tanning of any kind ___ None of these

How often do you wear sunscreen?

___ Always ___ Most Days ___ Occasionally ___ Rarely ___ Never

Do You Have Any of The Following Conditions:

___ Herpes (genital or cold sores) ___ Keloids scars ___ Acne ___ Seborrhea
___ Birthmarks ___ Thick scars ___ Eczema
___ Dark or hypopigmented scars ___ Medical conditions with excessive hair growth
___ None of These