



**Patient Information**

Date: \_\_\_\_\_ Full name: \_\_\_\_\_ Nickname \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_ Ext. \_\_\_\_\_

Email \_\_\_\_\_ D.OB. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation: \_\_\_\_\_ Would you like to receive our quarterly newsletter via email? \_\_\_\_\_

**\*Referral Source. Please be specific:** \_\_\_\_\_ **Emergency Contact/Phone#** \_\_\_\_\_

Please check next to the procedures or treatments you are interested in:

- |   |   |
|---|---|
| <input type="checkbox"/> Botox                            | <input type="checkbox"/> Brown/age/sun spot treatment     |
| <input type="checkbox"/> Injectable Fillers               | <input type="checkbox"/> Laser Hair Removal               |
| <input type="checkbox"/> Skin toning or pore refining     | <input type="checkbox"/> Spider Veins/ leg vein treatment |
| <input type="checkbox"/> Skincare products                | <input type="checkbox"/> Chemical Peels                   |
| <input type="checkbox"/> Acne Treatment                   | <input type="checkbox"/> Broken Capillaries on face       |
| <input type="checkbox"/> Fine Lines and wrinkle treatment | <input type="checkbox"/> Facial Redness                   |
| <input type="checkbox"/> Cosmetic Facial Surgery          | <input type="checkbox"/> Cosmetic Body Surgery            |
| <input type="checkbox"/> Laser Facial peels (Arctic Peel) | <input type="checkbox"/> Permanent Cosmetics              |
| <input type="checkbox"/> Laser Tattoo Removal             |   |

Other interests not listed: \_\_\_\_\_

**Do you use:** Tobacco? \_\_\_\_\_ yes \_\_\_\_\_ no How much? \_\_\_\_\_ Quit? When? \_\_\_\_\_  
 Alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ no How much? \_\_\_\_\_ Quit? When? \_\_\_\_\_

**Please check next to any current or past condition or treatment:**

- |  |           |          |               |
|--|-----------|----------|---------------|
| Retin-A  | _____ yes | _____ no | Explain _____ |
| Pregnant or trying?                                    | _____ yes | _____ no | Explain _____ |
| Bleeding/Clotting abnormalities                        | _____ yes | _____ no | Explain _____ |
| Fever Blisters/Cold sores                              | _____ yes | _____ no | Explain _____ |
| Keloid or thick scarring                               | _____ yes | _____ no | Explain _____ |
| White or brown scarring                                | _____ yes | _____ no | Explain _____ |
| Dark spots after pregnancy                             | _____ yes | _____ no | Explain _____ |
| Lupus or other autoimmune deficiency                   | _____ yes | _____ no | Explain _____ |
| Psoriasis or Vitiligo                                  | _____ yes | _____ no | Explain _____ |
| Diabetes   | _____ yes | _____ no | Explain _____ |
| Epilepsy   | _____ yes | _____ no | Explain _____ |
| HIV/AIDS   | _____ yes | _____ no | Explain _____ |
| Hepatitis  | _____ yes | _____ no | Explain _____ |
| Hirsutism  | _____ yes | _____ no | Explain _____ |
| Rheumatoid arthritis "Gold Therapy"                    | _____ yes | _____ no | Explain _____ |
| Pulmonary embolism/ Blood clot                         | _____ yes | _____ no | Explain _____ |
| Leg Ulcers or Phlebitis                                | _____ yes | _____ no | Explain _____ |
| Accutane Treatment                                     | _____ yes | _____ no | Explain _____ |
| Transplant anti-rejection drugs                        | _____ yes | _____ no | Explain _____ |
| Blood thinning medication                              | _____ yes | _____ no | Explain _____ |
| Waxing, plucking, electrolysis within the last 6 weeks | _____ yes | _____ no | Explain _____ |
| Chemical or Laser peels, resurfacing or facial surgery | _____ yes | _____ no | Explain _____ |

**Do you have a drug or latex allergies?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **no** **Explain/List** \_\_\_\_\_

Are you currently taking any medications, vitamins or supplements? \_\_\_\_\_

Please list any medical or surgical history \_\_\_\_\_

The information provided above is complete and accurate to the best of my knowledge and I understand that I am fully responsible for payment of services rendered. I also authorize Premier Image to take photographs for pre and post-operative evaluation purposes. These photos will remain the property of Premier Image.

**Signature of the Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Premier Image Cosmetic & Laser Surgery*  
*Premier Image Cosmetic & Laser Spa*



**Directions: Please circle the appropriate answer and then add up your total score.**

PATIENT NAME:	DATE:				
Score	0	1	2	3	4
What is the color of your eyes?	Light blue, gray, or green	Blue, gray, or green	Blue	Dark brown	Brownish black
What is the natural color of your hair?	Sandy red	Blonde	Brown, chesnut, dark blonde	Dark brown	Black
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never burns
To what degree do you turn brown?	Hardly, or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face return to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
TOTAL SCORE:	SCORE	FITZPATRICK SKIN TYPE			
SKIN TYPE:	0-7	I			
	8-16	II			
	17-25	III			
	26-30	IV			
	Over 30	V-VI			