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Patient Information

Name: Last Name First Name Middle Initial Today's Date: SS#

Home # ( ) Work # ( )

Cell # ( ) @ (phone carrier name) verizon / att / tmobile/ sprint / other: I authorize calls and text messages to the phone numbers provided above.

Address: Unit/ Apt #:

City: State: Zip:

Occupation: Employer:

E-Mail Address: Sex: F / M Age: Date of Birth : I authorize emails to the email provided above.

Marital Status: Name of Spouse: Anniversary Date:

# of children: In case of emergency, who should be notified? Phone ( )

What is your ethnic background (heritage):

Who may we thank for referring you?:

- Bing, CitySearch, Constant Contact, DemandForce, DoctorFinder.com, Doctor Referral, Dr.Score.com, Other, RealSelf, Instagram, Facebook, Friend Referral, Google, Google Maps, Groupon, Insider Pages, Vitals.com, LinkedIn, (friend's name), Our Location, Pinterest, Snapchat, Superpages, Twitter, Yahoo, Yellow Pages, Yelp, YouTube, MakeMeHeal.com

What is the reason for your visit today?

Medical History

- 1. Are you currently under the care of a physician and/or dermatologist? Yes No. If yes, please specify: Dr. Name: Dr. Phone # ( )
2. Are you allergic to penicillin, codeine, local anesthetics such as lidocaine, tranquilizers or any other drugs or medicine?
3. Do you have any food allergies?
4. What medications, vitamins or supplement including over-the-counter medications are you taking?
5. (Women) Are you pregnant or breastfeeding at this time? If so, how many months?
6. Have you taken or are you on Accutane?
7. Have you had aggressive exfoliation to your skin in the last two weeks?

8. What topical medications do you use or have you used: Retin A \_\_\_ Renova \_\_\_ Hydroquinone \_\_\_
9. Social History: Do you smoke? (include frequency) \_\_\_\_\_  
 Do you use alcohol? (include frequency) \_\_\_\_\_  
 Hobby/Leisure Activities: \_\_\_\_\_
10. Past Medical and/or Current Medical History (please read EACH one carefully):

	No	Yes	If yes, please explain:
Allergies and/ or Asthma			
Arthritis/Muscles/Joints			
Blood/Bleeding Disorder			
Blood Clotting Abnormalities			
Cancer: Skin Cancer, Malignant Melanoma, Other Cancer			
Diabetes			
Eyes, Ears/Nose/Throat/Mouth			
General Health			
Immunologic and/or Immune Disorder			
Hormone Imbalance			
Heart Disease and/or Hypertension (High blood pressure)			
Herpes (Cold sores)			
Headaches/Seizures			
Hepatitis			
HIV/AIDS			
Keloid Scarring			
Kidneys			
Lung Disease and/or Tuberculosis			
Rash, Peeling, Hives in last 6 months?			
Skin, Psoriasis and/or Eczema			
Stomach/Bowel			
Psychiatric			
Thyroid			

11. Do you consider your stress levels to be NONE, LOW, NORMAL **OR** HIGH? \_\_\_\_\_

12. Do you have a history of Psychiatric illnesses such as depression, anxiety, bipolar or schizophrenia? \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_

13. Health Issues/ Major Medical Illnesses/Surgeries: \_\_\_\_\_

14. What skin care products do you currently use? \_\_\_\_\_

15. Do you use an S.P.F. daily? \_\_\_\_\_

16. What treatment(s) on your skin and body have you had in the past? \_\_\_\_\_

\_\_\_\_\_

Please check mark what concerns you have:

- Acne (Blu-U, PDT, Accutane, Chemical Peel, Skin Care, Prescription Medication, Vibradermabrasion)
- Acne Scars (IPL, PDT, Laser Resurfacing, TotalFX, ScaarFX, Photofractional, Pico, Microneedling w/PRP, Bellafill)
- Age Spots (IPL, PDT, Laser Resurfacing, Chemical Peels, Vibradermabrasion, Medlite, Photofractional, Genesis, Excel V, Pico/ PiQo4)
- Aging Skin (IPL, PDT, Laser Resurfacing, Chemical Peels, Vibradermabrasion, Ultherapy, Genesis, Excel V, Microneedling w/PRP, TempSure Envi)
- Broken Capillaries (IPL, Electrosurgery, Genesis, Excel V)
- Brown Spots (IPL, PDT, Laser Resurfacing, Chemical Peels, Cosmelan, Genesis, Excel V, Pico/ PiQo4)
- Butt lift (Sculptra)
- Cellulite/ Fat Reduction/ Unwanted Fat (CoolSculpting, Meso-Slim, Weight Management Program, Sculptra, TempSure Envi)
- Cheek Augmentation (Juvederm Voluma, Radiesse, Sculptra, Restylane Lyft, Bellafill)
- Decolletage Wrinkles (Ultherapy, Botox, Belotero, Sculptra, Photofractional, Pico)
- Dermal Fillers (Juvederm Ultra XC & Plus XC, Juvederm Voluma, Volbella & Vollure, Restylane, Radiesse, Restylane Lyft & Silk, Sculptra, Belotero, Refyne, Defyne)
- Double Chin/Submental Fat (Kybella, CoolMini)
- Excessive Sweating/ Hyperhidrosis (Botox, Dysport, Ultherapy)
- Facials (Purifying, Antioxidant, Exfoliating, Acne, Vibraderm)
- Hair loss/thinning (PRP, Viviscal Professional)
- Hand Rejuvenation (IPL, PDT, Laser Resurfacing, Medlite, Dermal Fillers)
- Jawline Augmentation (Juvederm Voluma, Radiesse, Sculptra, Restylane Lyft, Bellafill)
- Laser Treatments (ActiveFX, DeepFX, TotalFX, ScaarFX -Laser Resurfacing, Pico/ PiQo4)
- Liquid Facelift (Botox, Dysport, Juvederm XC, Juvederm Voluma, Restylane, Radiesse, Sculptra)
- Loose Skin (Ultherapy, Laser Resurfacing, Meso-Slim, LaserFirm, Dermal Fillers, TempSure Envi)
- Melasma (IPL, PDT, Laser Resurfacing, Genesis, Excel V, Pico/PiQo4, Chemical Peels, Skin Lighteners)
- Moles/Skin Tags (Electrosurgery, Cryosurgery, Excision, Biopsy)
- Nasolabial Folds/ Smile Lines (Dermal Fillers: Juvederm, Restylane, Radiesse, Sculptra Aesthetic)
- Non-surgical Chin Enhancement – Chin Augmentation (Dermal Filler, Botox)
- Non-surgical Face, Neck & Décolleté lift (Ultherapy, TempSure Envi)
- Non-surgical Rhinoplasty/Nose augmentation
- Orgasmic dysfunction for women (ThermiVa, O-shot)
- Pearly Penile Papules
- Pigmentation (IPL, PDT, Laser Resurfacing, Genesis, Excel V, Pico/ PiQo4, Chemical Peels, Cosmelan, Medlite, Cryotherapy)
- Red Spots and/or Rosacea (IPL, Electrosurgery, V-Razor, Genesis, Excel V)
- Scar Removal (Laser Resurfacing, PDT, Kenalog, Microneedling)
- Skin Care Products (Acne, Anti-Aging, Brown Spots, Sensitive, Dry, Scars, Combination Skin)
- Skin Tightening (Laser Resurfacing, Ultherapy, TempSure Envi)
- Spider veins (Sclerotherapy, ND-Yag, Genesis, Excel V)
- Stretch Marks (IPL, Laser Resurfacing, ResurFX, Microneedling, Medical Grade Skin Care Products)
- Tattoo Removal (Pico/ PiQo4, Medlite C6)
- Thin Lips (Dermal Fillers: Juvederm Ultra & Plus XC, Juvederm Volbella, Voluma & Vollure Restylane Silk, Restylane-L, Radiesse, Refyne & Defyne)
- Thin and/or Dull Eyelashes (Latisse)
- Toenail Fungus (Genesis)
- Under Eyes Circles (IPL, Laser Resurfacing, Dermal Fillers)
- Unwanted Hair (Laser Hair Removal with Lightsheer Duet, Medlite C6, Pico/PiQo4, Excel V)
- Urinary Stress Incontinence (ThermiVa)
- Vaginal Rejuvenation (ThermiVa, O-shot for vaginal & vulva laxity, vaginal dryness, orgasmic dysfunction)
- Wrinkles (Laser Resurfacing, Botox, Dysport, Xeomin, Juvederm, Restylane, Radiesse, Sculptra, Bellafill)
- Other: \_\_\_\_\_

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

[www.mbc.ca.gov](http://www.mbc.ca.gov)

P. Alexander Ataii, M.D.

Physician and Surgeon

To the best of my knowledge, I have answered every question completely and accurately. I will inform my doctor of any change in my health and/or medication.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name(print)/ Relationship: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Fitzpatrick Skin Type Form

**Patient Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

<b>Genetic Disposition Score</b>	0	1	2	3	4
<b>What is the color of your eyes?</b> (choose only ONE)	Light Blue, Gray, Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
<b>What is your natural hair color?</b> (choose only ONE)	Sandy Red	Blond	Chestnut, Dark Brown	Dark Brown	Black
<b>What is the color of your non exposed skin?</b> (choose only ONE)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
<b>Do you have freckles on unexposed areas?</b> (choose only ONE)	Many	Several	Few	Incidental	None
<b>Total Score for Genetic Disposition</b>					

<b>Sun Exposure Reaction Score</b>	0	1	2	3	4
<b>What happens when you stay in the sun too long?</b> (choose only ONE)	Painful, Redness, Blistering, Peeling	Blistering Followed by Peeling	Burns Sometimes Followed by Peeling	Rare Burns	Never had Burns
<b>To what degree do you turn brown?</b> (choose only ONE)	Hardly or Not at All	Light Color Tan	Reasonable Tan	Tan Very Easy	Turn Dark Brown
<b>Do you turn brown within several hours of sun exposure?</b> (choose only ONE)	Never	Seldom	Sometimes	Often	Always
<b>How does your face react to the sun?</b> (choose only ONE)	Very Sensitive	Sensitive	Normal	Very resistant	Never had a Problem
<b>Total Score for Reaction to Sun Exposure</b>					

<b>Tanning Habits Score</b>	0	1	2	3	4
<b>When did you last expose your body to the sun or sunlamp tanning cream?</b> (choose only ONE)	More than 3 months ago	2 – 3 months ago	1 - 2 months ago	Less than 1 month ago	Less than 2 weeks ago
<b>Did you expose the area to be treated to the sun?</b> (choose only ONE)	Never	Hardly Ever	Sometimes	Often	Always
<b>Total Score for Tanning Habits</b>					

**STOP HERE!**

**FOR LASER CLINIQUE STAFF USE ONLY:**

**FITZPATRICK SKIN TYPE:**

**SUMMARY**

	Skin Type Score	Fitzpatrick Skin Type
<b>Total Score for Genetic Disposition</b>	<b>0 – 7</b>	<b>I</b>
<b>Total Score for Reaction to Sun Exposure</b>	<b>8 – 16</b>	<b>II</b>
<b>Total Score for Tanning Habits</b>	<b>17 – 25</b>	<b>III</b>
<b><u>SKIN TYPE SCORE</u></b>	<b>25 – 30</b>	<b>IV</b>
	<b>Over 30</b>	<b>V</b>