

Kavali Plastic Surgery

Laser Hair Removal and/or Laser Skin Rejuvenation Medical History and Skin Type Form

Date: _____ Name: _____

Please specify your genetic origin: African American Asian Caucasian Hispanic Mediterranean Middle Eastern
 Native American Other

Females: Are you pregnant? Y N
 Are you breastfeeding Y N
 Are you planning pregnancy during the course of your treatments? Y N
 During any past pregnancy, did you develop hyperpigmentation or masking? Y N
 Do you have regular periods? Y N
 Are you going through menopause? Y N

All patients: Medical History--Please check all that apply

<input type="checkbox"/> Acne	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Hirsutism	<input type="checkbox"/> Seizures
<input type="checkbox"/> Botox	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Shingles
<input type="checkbox"/> Burns/skin grafts	<input type="checkbox"/> Implants	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kaposi's Sarcoma	<input type="checkbox"/> Tattoos
<input type="checkbox"/> Endocrine disorders	<input type="checkbox"/> Keloid scars	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Epidermolysis bullosa	<input type="checkbox"/> Lupus erythematosus	<input type="checkbox"/> Vitiligo
<input type="checkbox"/> Filler injections	<input type="checkbox"/> Permanent makeup	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Gold therapy	<input type="checkbox"/> Polycystic ovary disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Port-wine stain	
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Precocious puberty	
<input type="checkbox"/> Herpes	<input type="checkbox"/> Psoriasis	

Are you currently being treated for any medical condition? Y N

If yes, please explain _____

Have you ever seen a physician regarding your skin? Y N
 Do you have any active skin diseases or infection in the area to be treated? Y N
 Do you have any skin allergies? Y N
 Have you had skin cancer or precancerous lesions? Y N
 Do you have psoriasis/eczema in the area to be treated? Y N
 Are there any moles with hair in the area to be treated? Y N
 Are you allergic to latex, lidocaine, or any lotions? Y N
 Have you had any surgery in the area to be treated? Y N
 Have you had any prior laser treatments or other skin treatments in the area to be treated? Y N
 Have you/are you using Accutane? Date of last use: _____ Y N
 Are you using Retin-A, Renova, Differin, or Tazorac? Date of last use: _____ Y N
 Are you using glycolic/AHA home care products? Date of last use: _____ Y N
 What skin care regimen are you currently using? _____
 Do you smoke? Y N
 Do you sunbathe? Date of last sun exposure to area to be treated _____ Y N
 Are you currently using, or have you used, a tanning bed or self tanner? Y N
 Do you use sunscreen? SPF _____ Y N
 Do you use facial depilatories (hair removal lotions)? Y N

Please indicate which of the following concerns you have regarding your skin?

<input type="checkbox"/> Aging	<input type="checkbox"/> Sun damage	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Age spots
<input type="checkbox"/> Acne	<input type="checkbox"/> Enlarged pores	<input type="checkbox"/> Blackheads	<input type="checkbox"/> Texture
<input type="checkbox"/> Redness	<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Whiteheads	<input type="checkbox"/> Other _____
<input type="checkbox"/> Leg veins	<input type="checkbox"/> Hair removal	<input type="checkbox"/> Oily skin	
<input type="checkbox"/> Spider veins	<input type="checkbox"/> Unevenness	<input type="checkbox"/> Dry skin	
<input type="checkbox"/> Scarring	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Sensitive skin	

What area would you like to treat for skin rejuvenation?
 Face and neck Chest Arms Hands Back Legs Other _____

Please specify which areas you would like to consider for laser hair removal? _____

