Welcome to TLC Laser & Skincare Center

INITIAL CONSULTATION

Date ____________________
Last Name ________________________ First Name ____________________M.I.______
Address____
City___________________________ State____________ Zip Code__________________
Age_______ Birth Date________________ Email ________________________________
Telephone: Home ___________________________ Cell ____________________________
Emergency Contact ______________________________Phone______________________

What would you prefer for reminders? (Circle one) **Email / Voice /Text** phone provider____________________
(AT&T, Verizon Etc.)

May we leave personal information on your answering machine/voicemail?
Yes ___ No ___

My TLC Rewards/ Newsletters are communicated through SMS/ Emails. Registration is on the tablet at time of checkout. Valid Email & phone number are required to register. **Initial**__________

We would appreciate knowing how and where you heard about us:
____ Mailer/ Magazine/ TV/ Radio/Billboard
____ Social Media
____ Physician
____ Relative/ Friend _______________________
____ Website/ Search Engine
____ Other (please specify) __________________

In order to provide you with the most appropriate skin renewal treatment, we would appreciate your time in completing the following information:

SKIN ASSESSMENT - CHECK ALL THAT APPLY:
□ Sun Damage
□ Brown Spots
□ Upper Lip Lines: □ Deep □ Fine
□ Freckles
□ Wrinkles: □ Deep □ Fine
□ Blackheads □ Whiteheads
□ Hard Bumps Under Skin
□ Milia
□ Clogged/Enlarged Pores
□ Excessive Oiliness
□ Acne
□ Pimples: □ Often □ Sometimes
□ Dry Patches
□ Visible Broken Blood Vessels

Type of Skin:
□ Dry □ Normal/Combination
□ Oily

SKIN CARE REGIME:
Please check the products you are currently using and list the **Brand Names:**
□ Cleanser _______________
□ Moisturizer _______________
□ Toner _______________
□ Scrub _______________
□ Eye Cream ______________
□ Night Cream ______________
□ Sunscreen ______________
□ RX Topicals ______________
□ Other ______________

SKIN TYPE:
Which of the following best describes your skin type?
□ I - Always burns, never tans
□ II - Always burns, sometimes tans
□ III - Sometimes burns, sometimes tans
□ IV - Always tans
□ V - Hispanic, Asian, Mediterranean, Middle Eastern
□ VI - Black

Ethnicity:

- ☐ Mediterranean
- ☐ French
- ☐ Irish
- ☐ Scandinavian
- ☐ Middle Eastern
- ☐ German
- ☐ Italian
- ☐ Other _____________
- ☐ African American
- ☐ English
- ☐ Asian
- ☐ Native American
- ☐ Greek
- ☐ Hispanic

MEDICAL HISTORY:

Do you have any of the following?

- ☐ Diabetes
- ☐ Drug Pump
- ☐ Thyroid
- ☐ Immune Deficiency
- ☐ Lupus
- ☐ Chemotherapy/ Radiation w/in 6 mo.
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Heart Murmur/Pulmonary Insufficiency
- ☐ Heart Attack
- ☐ Kidney/ Liver Disease or Failure
- ☐ Hernia
- ☐ Paroxysmal Cold Hemoglobinuria
- ☐ Metal Implants (IUD)/ Joint Replacements
- ☐ Bleeding Disorder/ Hemorrhagic Condition
- ☐ Phlebitis
- ☐ HIV
- ☐ Hepatitis
- ☐ Polycystic Ovarian Syndrome
- ☐ Hormone Issues
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Smoker - If so, how long? ___
- ☐ Seizures/ Epilepsy
- ☐ Raynaud's Disease
- ☐ Neuropathic Disorders
- ☐ Injured or Impaired Muscles
- ☐ Scleroderma/ Collagen Disease
- ☐ Skin Cancer
- ☐ Melanoma
- ☐ Flat warts/moles
- ☐ Keloid Scarring
- ☐ Pigmentation Disorder
- ☐ Shingles
- ☐ Cold Sores
- ☐ Permanent makeup/ tattoos
- ☐ Pregnant? Nursing?
- ☐ Cryoglobulinemia
- ☐ Accutane w/in 12 mo.

Other Medical Conditions or Surgical Procedures - Please explain ________________________________

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Drug Allergies: ____

____

Other Allergies: ____

CURRENT MEDICATIONS - including over-the-counter, herbal, or natural supplements:

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Signature of Patient/ Legal Rep: ______________________________________**Date**____________________

If signed by person other than patient, state relationship and authority to do so.

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled **Legal Authority:** ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Power of Attorney

______________________________Office use only______________________________

Notes____

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