

RENU LASER CENTER
SHAHIN ASSADNIA, MD (Medical Director)
1125 WEST 1ST NORTH STREET, SUITE B, MORRISTOWN, TN 37814
(423) 317-VEIN (8346) Phone (423) 317-6570 Fax

PATIENT PROFILE

NAME: _____ BIRTH DATE: _____

ADDRESS: _____ SEX: Male / Female

_____ AGE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

WHO REFERRED YOU ? _____ FAMILY DR.: _____

E-MAIL: _____

PATIENT HISTORY

List medications you currently take:

_____ Accutane ? Y / N

Allergies: _____

Do you have any health problems? Y / N Please list: _____

Are you currently pregnant ? Y / N Do you smoke ? Y / N Do you have skin allergies ? Y / N

Tanning History: (Including direct sun, self tanners, spray on tan, salon tanning): Please list and include last date of use: _____
How often ? _____

Do you have any tattoos ? If so please list location: _____

Have you ever had any tattoos removed ? Y / N : If so please list location: _____

Do you have any implants/injectables/permanent make-up ? If so please list: _____

AREAS OF PATIENT CONCERN

___ Lines/Wrinkles ___ Skin texture ___ Skin hydration ___ Skin elasticity

___ Even color tone ___ Acne (active) ___ Acne scars ___ Scars/stretch marks

___ Skin pigmentation/brown spots ___ Veins (___Legs ___Face)

___ Hair Removal Area of body ? _____

___ Other _____

Upon decision to purchase laser visits we require \$100 deposit that will go toward your balance. You must cancel at least 48 hrs in advance or risk loss of your deposit. _____ (Pts. initials)

PREVIOUS PROCEDURES

Have you ever had any previous laser treatments ? Y / N

(If so please specify date/number of treatments/frequency/response to treatment/device used, if known):

Have you ever seen a dermatologist for your skin ? Y / N (If so) Treatment: _____ Dr. _____

Have you ever had microdermabrasion ? Y / N

Have you ever had Collagen, Botox, Restylane injections ? Y / N (If so) Last Treatment ? _____ Where? _____

(Must wait 1 wk after Botox for treatment)

Previous hair removal history, if applicable: (Must wait 4-6 weeks before laser treatment)

Wax _____ Plucking _____ Electrolysis _____ Bleaching _____ Shaving _____ Date of last Treatment? _____

Have you ever had a facial or body peel? Please list: _____

CURRENT SKIN CARE PRODUCTS USED:

PATIENT SKIN ANALYSIS

Skin Type: _____ Oily _____ Dry _____ Extra Dry _____ Combination

Skin Color: _____ Fair _____ Olive _____ Black _____ Dark(Asian/Hispanic) _____ Other: _____

Skin type: _____ I _____ II _____ III _____ IV _____ V

Hair Type: _____ Coarse _____ Fine _____ Normal

Natural Hair Color: _____ Black _____ Blonde _____ Gray _____ Brown _____ Red _____ Other: _____

Large Pores: Y / N Fine Lines: Y / N Uneven pigmentation: Y / N Skin roughness: Y / N

Skin dryness: Y / N Elasticity: Y / N Cysts/nodules: Y / N Scarring: Y / N Where: _____

Facial veins: Y / N Angiomas: Y / N Hemangiomas: Y / N Irritation/Sensitive Skin: Y / N

Acne: Y / N Acne Scars: Y / N Stretch marks: Y / N Where: _____

Wrinkles: Y / N Where: _____ Leg veins: Y / N _____ Spider _____ Varicose

RECOMMENDATIONS: (Discuss)

____ 1. Treatment options (testing, color hair responds best, number of treatments). Benefits of laser treatment (possible long term hair removal).

____ 2. Client expectations (understand need for multiple treatments, after care, possible side effects, etc.)

____ 3. Laser technician and or physician consultation before or after test for a treatment recommendation.

____ 4. In detail full treatment schedule process (waiting period in between treatments, when to expect re-growth).

____ 5. Possible side effects (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.

____ 6. Specifics of area to be treated (test small area for tissue response BEFORE full treatment).

____ 7. Importance of sun exposure avoidance and the use of sunscreen during the entire treatment program. (SPF 30 or greater).

____ 8. Sensation of the laser/DCD spray and the option for topical anesthesia if requested. Laser safety required during treatment.

____ 9. Cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).

CLINICAL NOTES: Pictures taken today ? Y / N

See pictures on patient photo sheet.

COMMENTS: _____

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Client Signature: _____ Date: _____

Laser Skincare Authorized Signature: _____ Date: _____