Dr. R. van Aardt
Cosmetic Medicine

LASER/LIGHT CLIENT CONSULT

Date: _____

Name: _____ Date of Birth: _____

Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____

Email: _____ Consent to use: __Y __N

Address:

Please circle the applicable answer:

Y N Have you received any Laser / Light treatments in the past?
Y N Have you received any Medical Aesthetic treatments in the past?
If YES please list: _____
Y N Do you have any allergies: List: _____
Please list all medications you are currently taking: _____

_____ Pregnant / Trying to get pregnant _____ Diabetic _____ Immune Compromised
_____ Hormonal conditions PCOS or pigment brought on by pregnancy or hormonal changes

This questionnaire is intended as a guide for skin typing. Final evaluation will be determined by Professional Service Provider:

Question	0	1	2	3	4
What is the color of your eyes?	Light Blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin? (Non-exposed areas)	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful, blistering, redness, peel	Burns followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had a burn
To what degree do you turn brown?	Hardly or not at all	Light colour tan	Reasonable tan	Tan very easy	Turn dark brown
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose your body to the sun, sun bed or artificial sun cream?	More than 3 months ago	2 - 3 months ago	1 - 2 months ago	Less than one month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

_____ I acknowledge that before, during and after photographs will be taken of the treatment area.

_____ I consent that these photographs may discreetly be used for promotional or educational purposes by this Medi-Spa.

_____ I certify that I have been fully informed of the nature and purpose of the laser / light assisted procedure, expected outcomes and possible complications.

_____ I understand that Laser Skin Blemish Removal must be Physician consulted

_____ **I have signed additional consent for my specific Laser / Light Assisted Procedure.**

By signing below I hereby acknowledge that the above information are true and correct as per my knowledge.

Print name of Client	Signature of Client	Date
Print name of Service Provider	Signature of Service Provider	Date

Office use only: _____ **Total Score of Questionnaire**

0 - 7 Fitzpatrick Scale I	**8 - 16 Fitzpatrick Scale II**	**17 - 25 Fitzpatrick Scale III**
26 - 30 Fitzpatrick Scale IV	**30 + Fitzpatrick Scale V - VI**	