

**SOUTHWEST WOMEN'S CARE**  
**Hair & Vein Removal • Sun Spot Removal • Botox • Juvederm**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

**Best phone number to contact you regarding your treatment and where we may leave a message:**

Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ ext: \_\_\_\_\_

VIP Email: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

***This information is necessary for your procedure. Please answer YES or NO to the following questions:***

**YES**

**NO**

- Are you using any prescribed medications? List: \_\_\_\_\_
- Are you using any Herbal medications? List: \_\_\_\_\_
- Do you take oral anti-coagulant (blood thinning) medication? List: \_\_\_\_\_
- Are you allergic to any cosmetic ingredients, medications or foods? List: \_\_\_\_\_
  
- Are you pregnant or trying to become pregnant?
- Are you breastfeeding?
- Do you use oral contraceptives?
- Do you use hormone replacement therapy?
- Do you smoke? How much? \_\_\_\_\_ How long? \_\_\_\_\_
- Do you spend a lot of time outdoors or use a tanning bed often?
- Do you have any tattoos or permanent makeup?

Please tell us your main concerns that brought you to our office today: \_\_\_\_\_

<b>* REQUIRED FOR SKIN ANALYSIS &amp; TREATMENT *</b>	
Your Ethnicity: _____	
Mother's Ethnicity: _____	Father's Ethnicity: _____
Are you tan? _____	Do you tan artificially? _____ Tanning Bed _____ Spray-on Tan _____
When was the last time you had a significant amount of sun exposure? _____	

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- Sun Damage
- Brown spots (Hyperpigmentation)
- White spots (Hypopigmentation)
- Uneven skin tone
- Visible exposed blood vessels
- Hard bumps under skin
- Enlarged pores
- Clogged pores
- Blackheads
- Whiteheads
- Acne
- Excessive oiliness
- Pimples
- Upper lip lines
- Wrinkles
- Scarring
- continued...

- Sun Spots                       Dry patches                       Unwanted Hair  
 Other: \_\_\_\_\_

What is your skin type:  Dry                       Combination                       Oily                       Normal

How much water do you consume per day? \_\_\_\_\_

**Please check the products you currently use and list the BRAND NAMES of the cosmetic products:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cleanser _____        | <input type="checkbox"/> Soap _____            | <input type="checkbox"/> Toner _____             |
| <input type="checkbox"/> Moisturizer _____     | <input type="checkbox"/> Night Cream _____     | <input type="checkbox"/> Mask _____              |
| <input type="checkbox"/> Eye Cream _____       | <input type="checkbox"/> Astringent _____      | <input type="checkbox"/> Glycolic Wash/Cleanser  |
| <input type="checkbox"/> Scrub _____           | <input type="checkbox"/> Sunscreen _____       | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream _____ | <input type="checkbox"/> Vitamin C Cream _____ | <input type="checkbox"/> Alpha/Betahydroxy Cream |
| <input type="checkbox"/> Makeup _____          | <input type="checkbox"/> _____                 | <input type="checkbox"/> _____                   |

**Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? Please list:** \_\_\_\_\_

**Have you ever had any of the following wrinkle fillers or implants:**

- Collagen     Restylane     Perlane     Hylaform     Juvederm     Silicone     Radiance  
 Sculptra     Other: \_\_\_\_\_

\* If so, then when was it done? \_\_\_\_\_ What area? \_\_\_\_\_ By whom? \_\_\_\_\_

**Please check any health problems, past or present:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Liver disease   | <input type="checkbox"/> Skin cancer (Type: _____)  |
| <input type="checkbox"/> Hormonal Problems   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Cystic Acne <input type="checkbox"/> Thyroid <input type="checkbox"/> Cancer     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Health problems | <input type="checkbox"/> Collagen <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Vasovagal Syncope   | <input type="checkbox"/> PCOS            | <input type="checkbox"/> Autoimmune (lupus, scleroderma) <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Other: _____        |  |   |

**Do you have any of the following chronic skin disorders?**

- |   |                                     |                                       |  |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Keloid Scarring         |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |

**Have you ever undergone any of the following treatments?**

- |  |                                    |   |                                 |
|--|------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Macrodermabrasion | <input type="checkbox"/> Acid Peel | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Lasers |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Botox     | <input type="checkbox"/> Accutane         |                                 |

When and where was it done? \_\_\_\_\_

**Are you currently removing hair by any of the following methods?**

- Waxing     Tweezing     "Nair" type products     Electrolysis     Laser Hair Removal
- If so when was it done? \_\_\_\_\_ What area? \_\_\_\_\_ And what type of laser? \_\_\_\_\_

**I certify that the above information is correct to the best of my knowledge.** \_\_\_\_\_  
*Patient Signature*

Southwest Women's Care Notes: \_\_\_\_\_

\_\_\_\_\_

## Skin Type Worksheet

Client Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Score	Analysis	0	1	2	3	4
	What is the color of your Eyes?	Light Blue, Gray or Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your Hair?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	What is the color of your skin? ( <i>unexposed areas</i> )	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, Blistering, Peeling	Blistering followed by Peeling	Burns, sometimes followed by peeling	Rarely Burns	Never had Burns
	To what degree do you turn brown?	Hardly or not at all	Light Color Tan	Reasonable Tan	Tan very easily	Turn Dark Brown Quickly
	Do you turn Brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1-Month Ago	Less than 2 Weeks Ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
<b>Total:</b>	<b>Score</b>	<b>Fitzpatrick Skin Type</b>				
	<b>0 – 7</b>	<b>I</b>				
	<b>8 – 16</b>	<b>II</b>				
	<b>17 – 25</b>	<b>III</b>				
	<b>25 – 30</b>	<b>IV</b>				
	<b>Over 30</b>	<b>V - VI</b>				