Boston Vein Care

Skin Health History Questionnaire

Client Name: _____Date of Birth: _____Age_____

Address: _____City: _____ _____State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____How did you hear about us? _____

Emergency Contact Person: _____Relationship: _____Phone: _____

Please indicate the service and areas of interest

- ☐ **Laser Vein Removal**
- ☐ **Laser Hair Reduction**
- ☐ **Other: _____**

☐ Abdomen	☐ Buttocks	☐ Neck
☐ Arms	☐ Chest	☐ Stomach
☐ Back	☐ Face	☐ Underarms
☐ Bikini	☐ Legs	☐ Other:_____

☐ **Skin Rejuvenation**

☐ Acne Scarring	☐ Freckles	☐ Rosacea
☐ Age Spots	☐ Large Pores	☐ Skin Tightening
☐ Blackheads	☐ Leathery Texture	☐ Spider/Varicose Veins
☐ Broken Capillaries	☐ Lip Lines	☐ Sun Damage
☐ Crow's Feet	☐ Loss of Firmness/Elasticity	☐ Uneven Skin Color
☐ Dry/Rough Skin	☐ Nasolabial Lines	☐ Wrinkles Deep/Fine

☐ **Cellulite Reduction/ Body Contouring/ Circumferential Reductions**

☐ Abdomen	☐ Buttocks	☐ Lower Back
☐ Arms	☐ Hips	☐ Thighs

Do you have or have you ever had any of the following conditions?

Yes	No	Condition	Explain
		Seizures and/or Epilepsy	
		Diabetes	
		Numbness in the area	
		Autoimmune Disorder	
		Sarcoidosis	
		Skin Disorders	
		Lupus	
		Scleroderma	
		Vitiligo	
		Keloid/Hypertrophic Scarring	
		Present Scarring	

		Herpes Virus/Cold Sores	
		Polycystic Ovarian Syndrome	
Yes	**No**	Peripheral Vascular Disease	
		Lymphedema	
		Varicose Veins	
		Pregnancy/Actively trying to conceive	
		Cancer and/or Precancerous Lesions	
		HIV/AIDS	
		Multiple Sclerosis	
		Chemotherapy/Radiation	
		Pacemaker/Internal Pacing Devices	
		Internal Metal Devices (rods, plates, screws)	
		Hip Replacement	
		Lymph Node Removal	
		Hernias	
		Past Surgeries	

Medication History

		Current Medications	
		Over the counter medications	
		Herbal Supplements	
		Retin-A or Generics	
		Blood Thinner (Coumadin, Asprin)	
		Acne Medication	
		Oral Contraceptives	
		Accutane	
		Antibiotics	

Allergies

		Food Allergies	
		Medication Allergies	
		Latex Allergies	

Other

		Permanent Make-up	
		Tattoos	
		Recent Cosmetic Procedures	
		Botox/Dermal Fillers	

Product History

		Cleaners	
		Soap	
		Toner	
		Moisturizer	
		Night Cream	
		Eye Cream	
		Astringent	
		Scrub	
		Sunscreen	
		Other	

Type of Skin

○ Dry	○ Normal	○ Oily	○ Combination	○ Acne-Prone

Fitzpatrick Skin Typing Questionnaire

Genetic Disposition

Score	0	1	2	3	4
Your natural eye color?	Light blue, green or gray	Blue, green or gray	Blue	Dark Brown	Brownish Black
Natural hair color?	Sandy, red	Blonde	Chestnut, Dark blonde	Dark brown	Black
Color of your non-exposed skin?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on the unexposed area?	Many	Several	Few	Incidental	None

Total score for genetic disposition: _____

Reaction to Sun Exposure

Score	0	1	2	3	4
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 burns
To what degree do you turn brown?	Hardly, or not at all	Light color tan	Reasonable tan	Often	Always
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

Total Score for reaction to sun exposure: _____

Tanning Habits

Score	0	1	2	3	4
When did you last expose your body to sun or tanning booths/creams?	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

Total score for tanning habits: _____ **Total score from all areas: _____**

Fitzpatrick Skin Type

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V-VI

I have answered all the questions truthfully and to the best of my knowledge

Client Signature: _____Date: _____

Staff Signature: _____Date: _____