

FRAXEL® Pre Procedure Patient Assessment

Laser Center of Southlake
521 W. Southlake Blvd #175
Southlake TX 76092

Date: _____ M F Age: _____

Allergies/sensitivities/type of reaction: _____

Chronic medical conditions: no yes, list: _____

Known blood borne infection? no yes, describe: _____

Current anticoagulants or medications, herbals that can affect coagulation? no yes, list: _____

Using products with glycolic acid or retinols? no yes, describe: _____

Previous history of cold sores? no yes

Previous face lift? no yes, when: _____

Previous resurfacing? no CO₂ Er:YAG Other _____
When? _____

Previous history of fillers? no yes explain: _____

Previous history of melasma/PIPA? no yes, explain: _____

Does patient exhibit any evidence of melasma or PIPA? no yes, explain: _____

Are there telangiectasias, vascular malformations present? no yes, explain: _____

Previous history of keloid formation? no yes

Isotretinoin (or Accutane®) use within last 6 months? no yes

Are any lesions suspicious for cancer? no yes (This is an absolute treatment contraindication)

Circle as appropriate: Fitzpatrick Skin Type I II III IV V VI

Glogau Photoaging I II III IV

Fitzpatrick Wrinkle Score MILD 1 2 3 MODERATE 4 5 6 SEVERE 7 8 9

Treatment Indication: _____

Treatment Indication: _____

Pre treatment regimens/instructions: check and describe, if instituted.

HSV _____

Bleaching agent _____

Stop Hydroquinone _____ prior to procedure

Stop products containing glycolic acid, retinols, and retinoids _____ prior to procedure.

Procedure explained

Written instructions given to patient.

Provider signature _____ Date _____

**FRAXEL® Pre Procedure
Patient Assessment**

Laser Center of Southlake
521 W. Southlake Blvd #175
Southlake TX 76092

Notes/Treatment plan:

Provider signature _____ Date _____