

VeinTherapies

Laser Skin and Vein Solutions
 W. Clark Beckett, M.D., F.A.C.S.
 3770 7th Terrace #102, Vero Beach, FL 32960
 772.567.6602 fax 772.567.7754

Fitzpatrick Skin Type Form

Score	0	1	2	3	4
What color are your eyes?	light blue, gray 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 (non-exposed areas)?	reddish	very pale	pale with beige tint	light brown	none
Do you have freckles on unexposed areas?	many	several	few	incidental	none

Total score for genetic disposition

Score	0	1	2	3	4
What happens when you stay too long in the sun?	painful redness, blistering, peeling	blistering, followed by peeling	burns sometimes followed by peeling	rare burns	never had burns
To what degree do you turn brown?	hardly or not at all	light color tan	reasonable tan	tan very easy	turn dark brown quickly
Do you turn brown within several hours of 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

Score

When did you last expose your body to sun (or artificial sunlamp/tanning cream?)	more than 3 months ago	2-3 months ago	1-2 months ago	less than a 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

Summary

		Skin Type Score	Fitzpatrick Skin Type
<input type="text"/>	Genetic Disposition	0-7	I
<input type="text"/>	Sun Exposure	8-16	II
<input type="text"/>	Tanning Habits	17-24	III
<input type="text"/>	Total Skin Type Score	25-30	IV
		over 30	V

Patient Name: _____

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DATE: _____

PATIENT EMAIL: _____
(to receive emails on our latest laser information)

How did you hear about us? (circle one) Friend Press Journal Physician VB Magazine

Other _____

SECTION A: PATIENT INFORMATION

NAME:

LAST _____ FIRST _____ INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ DATE OF

BIRTH _____

SECONDARY ADDRESS _____

CITY _____ ST _____ ZIP _____ PHONE _____

PATIENT SOCIAL SECURITY # _____ MARITAL STATUS _____

PERSON RESPONSIBLE FOR BILL _____ REFERRED BY _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE # _____

SECTION B: SPOUSE INFORMATION

NAME _____ DATE OF BIRTH _____ SOC.SEC.# _____

EMPLOYER _____ OCCUPATION _____

STREET ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____ PHONE _____

RELATIVE _____ RELATIONSHIP _____ PHONE _____

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Date_____

Patient email:_____

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How did you hear about us? (circle one) Friend Press Journal Physician VB Magazine Other_____

Patient History

Name_____ Gender M F Age____ Date of Birth_____

(We may attempt to contact you at any of the numbers/addresses you provide. While we always try to be as discreet as possible, please do not provide numbers at which you do not wish to be contacted)

Please circle the items below that apply to you:

Hair Removal (last 6 weeks): plucking waxing depilatories (like Nair®) electrolysis

Tanning (last 6 weeks): sun exposure tanning bed tanning products

Medications: Retin-A (last 3 weeks) Accutane (last 6 months)

Sensitivity to: hydroquinone (bleaching agents) glycolic acid (skin cleansers)
Lidocaine (anesthetics) other_____

Skin Conditions: skin infection herpes (cold sores) keloids/excessive scarring sun sensitivity
skin cancer poor healing/diabetes easy bruising or bleeding eczema
tattoos/permanent make-up

Previous Procedures: laser/light treatments microdermabrasion chemical peels
other_____

Medical History: Pregnant? Y N Maybe N/A
Any current illness, disease or condition? Y N
Current medications (include aspirin, hormones, and contraceptives):

Allergies (include aspirin)_____

Skin Concerns: Hair Wrinkles Spider Veins Skin Flushing (redness) Acne
Texture (pores/pits, scarring, aging) Coloration (dark, age or sun spots)
Other_____

Area of Interest: Hair removal Skin Renewal Microdermabrasion Acne Treatments Skin Care Products

Patient Signature_____ Date_____

Technician's Notes:_____

Signed: _____

Meredith L. Harris, M.S., A.R.N.P.