



**CAROLINA FAMILY MEDICINE AND DERMATOLOGY, PA/
CAROLINA LASER and COSMETIC CENTER
Anne L. White, M.D.**

Patient Name: _____ Date: _____

At Carolina Laser and Cosmetic Center, your happiness and satisfaction are of paramount importance to us. In our extensive experience, we have found that well-chosen interventions and procedures result in the greatest improvement in your appearance, affording you maximum satisfaction and improvement in the quality of your life.

The following questions will help us in tailoring the best interventions to meet your cosmetic and lifestyle needs.

Please be honest so that you can help us to understand you as a unique individual.

COSMETIC PROCEDURE SCREEN – DERM (CPS-D)

Please specify the cosmetic/skin problem(s) that bother you.

Please specify the cosmetic/skin problem(s) you would like improved or corrected.

How do you envision your life will change after your cosmetic procedure?

Will having a cosmetic procedure “fix” any of your problems? Yes No

Have you seen any other physicians for cosmetic concerns? Yes No

If yes, how many? _____

What were your concerns?

Were you satisfied with the results?

Have you had any previous cosmetic procedures? If yes, which ones?

Were you happy/satisfied with the results?

Do you drink alcohol? Yes No How often? How much _____

Are you taking prescription medications for pain? Yes No If yes, which ones?/How often?

Do you feel overwhelmed or confused? Yes No

Are you being strongly encouraged or discouraged from having a cosmetic procedure?
Yes No

Are you generally satisfied with your life? Yes No

Are you worried about the way you look and wish you could think about it less? Yes
No

How many minutes or hours in an average day do you think about how you look?
_____ minutes _____ hours

Do you cut or otherwise purposely harm your skin? Yes No

Are so distressed by your cosmetic concern to the point where it interferes with your
ability to be happy or carry out your necessary daily chores? Yes No

Have your cosmetic concerns gotten in the way of doing things with your friends and
family? Yes No

Do you work outside of the home? Yes No

Where do you work? _____

What kind of work do you do? _____

Please Circle the best response to each question.

Score	0	1	2	3	4
What are 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	Blonde	Dark Blonde	Dark brown	Black
What is the color of your skin?	Reddish	Very Pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles in unexposed area?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness/ blistering/ peeling	Blistering followed by peeling	Burns followed by peeling	Rarely burns	Never been burned
Do you turn brown within 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?	> 3 months ago	2-3 months ago	1-2 months ago	< a month ago	< 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Nurse to complete:

Add responses by number.

- 0-7: Type 1
- 8-16: Type 2
- 17-25: Type 3
- 25-30: Type 4
- 30-34: Type 5
- 34-36: Type 6