SALEM COSMETIC CLINIC
For all your cosmetic needs

Patient Record Sheet
Fractional CO2 Laser Resurfacing

Shanmuga Hospital
A legacy of caring

Name:_____ Address:_____
Registration No.:_____
General Information
Age:_____ Sex:_____
Mobile No.:_____ Diagnosis:_____

1. Any photosensitive disorder: SLE/rosacea/blooms, etc.
2. Photosensitive medication: captopril/NSAID/tetracyclines, retinoids, etc.
3. Bleeding disorders: yes/no
4. Any implants/prosthesis: yes/no
5. Keloidal tendencies: yes/no
6. Any infections at the site: herpes labialis, genitalis, zoster, etc.
7. Pregnancy: yes/no
8. History of convulsions: yes/no
9. Isotretinoin within the last 6 months: yes/no.

Fitzpatrick's skin type: I, II, III, IV, V, VI

Information of scar:

1. Site of scar:_____
2. Onset: acute/insidious
3. Duration: _____
4. Dimension: _____
5. Hypertrophic / Atrophic / Acne scar
6. Cause of scar: acne/varicella/trauma/burn/others
7. Grade of acne scar: I/II/III/IV
8. Any superficial skin changes: _____
9. Color of the scar: dark/red/whitish
10. Keloidal tendency: yes/no
11. Symptoms on the scar: pruritus/pain
12. Any contracture/deformity:_____.

Treatment Record Sheet

Name:_____ Registration No.:_____

Skin type:_____

Treating doctor:_____

Age:_____ Sex:_____

Mobile No.:_____ Diagnosis:_____

Treatment area:_____

No. of session	1	2	3	4	5	6
Date						
Anesthesia used (yes/ no)						
Consent taken (yes/no)						
Name of laser						
Wavelength						
Fluence/energy						
Pulse duration						
Pulse delay						
Density						
Mode (superficial/deep)						
Scanner type used						
No. of pass						
Spot size						
Frequency (Hz)						
No. of pulses						
Any complications						
Signature of doctor						

SALEM COSMETIC CLINIC
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Patient Record Sheet
Laser Hair Reduction

Shanmuga Hospital
A legacy of caring

Name:_____ Registration No.:_____
Age:_____ Sex:_____
Mobile No.:_____ Diagnosis:_____

1. Any photosensitive disorder: SLE/rosacea/blooms, etc.
2. Photosensitive medication: captopril/NSAIDs/tetracyclines, retinoids, etc.
3. Bleeding disorders: yes/no
4. Any implants/prosthesis: yes/no
5. Keloidal tendencies: yes/no
6. Any infections at the site: herpes labialis, genitalis, zoster, etc.
7. Pregnancy: yes/no
8. History of convulsions: yes/no
9. Isotretinoin within the last 6 months: yes/no.

Fitzpatrick's skin type: I, II, III, IV, V, VI

Other history:

1. Clinical signs of hormonal disturbances: obesity, menstrual irregularities, acanthosis, FPHL, acne
2. Any documented hormonal disturbances: PCOS, hypothyroidism, etc.
3. Specific investigations:
    - Serum testosterone level
    - LH/FSH ratio
    - Fasting and postprandial insulin level
    - Ultrasound of abdomen and pelvis
    - Serum TSH, free T4, free T3.
4. History of ingestion of drugs like phenytoin, cyclosporine, OCPs, etc.

Areas to be treated:

1.
2.
3.
4.

Hair types:

1. Thick, dense
2. Thick, less dense
3. Thinner, less dense
4. Very fine hair (vellus), very low hair density.

Treatment Record Sheet (Laser Hair Reduction)

Name:_____ Registration No.:_____

Skin type:_____

Treating doctor:_____

Modified Ferriman-Gallwey score for hirsutism :

Age:_____ Sex:_____

Mobile No.:_____ Diagnosis:_____

Treatment area:

Site	Upper lip	Chin	Chest	Upper back	Lower back	Upper abdomen	Lower abdomen	Upper arms	Thighs
Score (0–4)									
Total score									

No. of session	1	2	3	4	5	6
Date						
Anesthesia used (yes/no)						
Consent taken (yes/no)						
Name of laser						
Wavelength						
Fluence/energy						
Pulse duration						
Pulse delay						
Spot size						
Frequency (Hz)						
No. of pulses						
Any complications						
Signature of doctor						

SALEM COSMETIC CLINIC
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Patient Record Sheet
Laser Pigment / Tattoo Removal

Shanmuga Hospital
A legacy of caring

Name:_____ Address:_____
Registration No.:_____
Age:_____ Sex:_____
Mobile No.:_____ Diagnosis:_____

1. Any photosensitive disorder: SLE / rosacea / blooms, etc.
2. Photosensitive medication: captopril/ NSAIDs / tetracyclines, retinoids, etc.
3. Bleeding disorders: yes / no
4. Any implants/prosthesis: yes / no
5. Keloidal tendencies: yes / no
6. Any infections at the site: herpes labialis, genitalis, zoster, etc.
7. Pregnancy: yes / no
8. History of convulsions: yes / no
9. Isotretinoin within the last 6 months: yes / no.

Fitzpatrick's skin type: I, II, III, IV, V, VI

Information of pigmented lesion / Tattoo:

1. Lesion present since: _____
2. Onset: acute / insidious / pregnancy / drug intake
3. Site: _____
4. Unilateral / bilateral
5. Size: _____
6. Number of lesions / Tattoo : single / multiple
7. Previous treatment: yes / no
8. History of similar lesion in family: yes / no
9. Any other dermatologic/systemic association: _____.

Treatment Record Sheet (Laser Treatment for Pigmentation Removal)

Name:_____ Registration No.:_____

Skin type:_____

Treating doctor:_____

Age:_____ Sex:_____

Mobile No.:_____ Diagnosis:_____

Treatment area:_____

No. of session	1	2	3	4	5	6
Date						
Anesthesia used (yes/no)						
Consent taken (yes/no)						
Name of laser						
Wavelength						
Fluence/Energy						
Standard/fractional						
Spot size						
Frequency (Hz)						
No. of pulses						
Any complications						
Signature of doctor						