James L. Masdon, M.D.
Board Certified

Date: _____

Masdon ENT & Facial Plastic Surgery

Fraxel® Pre-Procedure Patient Assessment

Patient Name: _____ Date of Birth: _____ Age: _____
☐Male ☐ Female
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
_____

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 ☐CO_2 ☐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 melisma or PIPA? ☐ No ☐ Yes Explain: _____
Are there telangiectasias, vascular malformations present? ☐ No ☐ Yes Explain: _____
Previous history of keloid formation? ☐ No ☐ Yes
Isotretnoin (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: _____

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602 Corley Avenue Boaz, Alabama 35957
Phone: (256) 571- 8450 Fax: (256) 840 – 4584
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Notes/Treatment Plan:

Provider Signature _____ Date _____

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