SKIN CANCER & COSMETIC
DERMATOLOGY CENTER

BRING THIS FORM WITH YOU TO YOUR NEXT LASER TREATMENT

Patient: _____

Date of Treatment: _____ Time of Treatment: _____

Please complete this form between 16 and 24 hours after your treatment by checking the appropriate boxes:

Area 1: (list area) _____

Coloration	None ☐	Light Pink ☐	Medium Pink ☐	Hot Pink ☐	Red ☐
Temperature / Heat	None ☐	Warm to the Touch ☐	Hot to the Touch ☐		
Sensitivity/Pain	None ☐	Some Sensitivity ☐	Painful to the Touch ☐		

Area 2: (list area) _____

Coloration	None ☐	Light Pink ☐	Medium Pink ☐	Hot Pink ☐	Red ☐
Temperature / Heat	None ☐	Warm to the Touch ☐	Hot to the Touch ☐		
Sensitivity/Pain	None ☐	Some Sensitivity ☐	Painful to the Touch ☐		

Comments _____