Acne patient treatment record form

Patient ID/Name:________________________________ Date:________________________________

Patient ID: ____________________________________ Patient Email:__________________________

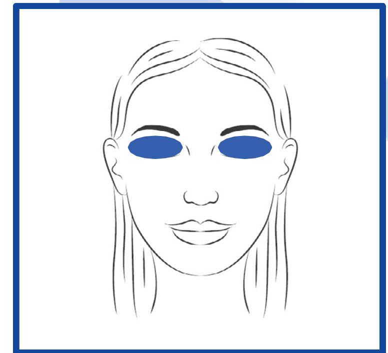
Treatment #:______________ Treatment area(s): ________________________

Skin type: I II III IV V VI

Acne severity rating: Clear Almost Clear Mild Moderate Severe

Technician: ___________________________________

Pre-treatment meds: _____________________________



Sun exposure since last treatment? ☐ Yes ☐ No _________

Change in meds/health medical history? ☐ Yes ☐ No _________

Complications since last treatment? ☐ Yes ☐ No _________

Photos taken? ☐ Yes ☐ No

Post-op form to patient? ☐ Yes ☐ No

Treatment Area	Single-Spot or 7-Spot Array	Fluence	Temp	# Of Pulses
Reaction				
Reaction				
Reaction				
Reaction				

Signature:____ Date: ___________________

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