

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Today's Date: _____

Home Phone: _____ Business Phone: _____

Cell # or Preferred Contact #: _____ Is it important to be discrete? _____

How did you hear about us? _____

Describe the nature of your visit? _____

What are your expectations? _____

Please fill out any of the following that may apply:

Medical History:

Heart Condition: _____ Keloids: _____

Diabetes: _____ Cold Sores/Herpes: _____

Perm Makeup/Tattoos: _____ Pregnant or Lactating: _____

Have you been on Accutane in the past 6 months? _____

Include any other medications that make you photo sensitive: _____

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin etc.): _____

Any Allergies: _____

Acne:

Do you have a history of breakouts? _____ Yes _____ No

If so, what is the frequency of your breakouts? _____ Frequent _____ Occasional _____ Rarely

Do you experience cystic breakouts? _____ Yes _____ No

Do you have any scarring as a result from your acne? _____ Yes _____ No

Skin Background:

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? _____ Yes _____ No

If so, are you currently sunburned? _____ Yes _____ No

Do you use tanning beds? _____ Yes _____ No

Are you using chemical tanning solutions? _____ Yes _____ No

Do you use sunscreen on a regular base? _____ Yes _____ No

Fitzpatrick I-VI:

Check one (when exposed to the sun without protection for approximately 1 hour):

- (I) Always burns, never tans (IV) Rarely burns, tans more than average
 (II) Usually burns, tans less than average (V) Rarely burns, tans profusely
 (III) Sometimes mild burn, tans about average (VI) Never burns, deeply pigmented

Skin Type:

Caucasian _____

Hispanic _____

Mediterranean _____

African American _____

American Indian _____

Other: _____

Tan:

Have you waxed, used depilatories, bleaches or other chemical processes? Yes No

How much water do you normally consume daily? _____

Do you exercise? Yes No

Do you smoke? Yes No

Have you had microdermabrasion? Yes No

Have you had any chemical peels? Yes No

Have you had laser resurfacing? Yes No

Do you have rosacea? Yes No

Do you have wrinkle concerns? Yes No

Do you have scarring concerns? Yes No

Do you have sun damage concerns? Yes No

Do you have pigmentation concerns? Yes No

Do you have broken capillary concerns? Yes No

Have you had Botox or Collagen injections in the past 6 months? Yes No

If yes and less than 3 months, approximate dates? _____

Do you use topical ointments? Retin-A Glycolic Lactic Acid

Hydroquinone Other: _____

What type of skin care products are you using? _____

Check other services of interest:

Laser Hair Removal (list different areas) _____

Laser Vein Removal

Non-ablative LaserFACIAL

Pigmented Lesions or Brown Spot Removal

Other: _____

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____

DR/Tech Signature: _____ Date: _____