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

Skin Type:	**Tan:**	
Caucasian _____	_____	
Hispanic _____	_____	_____
Mediterranean _____	_____	
African American _____	_____	
American Indian _____	_____	
Other: _____	_____	

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 then 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: _____