Laser Skin & Wellness

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Name_____ Today's Date _____/_____/_____
Last First Mo Day Yr

Address:_____ Birthdate _____/_____/_____Age_____
Mo Day Yr

City:_____ State:_____ ZIP:_____ Gender M_____ F_____

Best phone number to contact you regarding your treatment and where we may leave a message:

Phone: ( ) _____ Cell / Work / Home

E-mail_____ **How did you hear about us?** _____

Primary Care Physician _____ Phone Number _____

Pharmacy _____ Phone Number _____

Occupation:_____

In Case of Emergency: Name:_____Relationship_____Phone_____

What brought you to our office today: _____

This information is necessary. Please answer yes or no to the following questions:

YES	**NO**	
❑	❑	Are you in good health at the present time?
❑	❑	Are you using any prescribed medications? List_____
		_____
❑	❑	Are you using any Vitamins/Minerals medications? List_____
		_____
❑	❑	Do you take oral blood thinning medications/supplements? List _____
❑	❑	Are you ***allergic*** to any cosmetic ingredients, medications, foods, environment? List_____
		_____
❑	❑	Do you smoke? How much? _____ How long?_____
❑	❑	Do you spend a lot of time outdoors or use a tanning bed often?
❑	❑	Do you have any tattoos or permanent makeup?

FOR WOMEN:

First Period_____ Pregnancies: Number_____ Natural Delivery or C-Section_____ Last Period_____

❑	❑	Are you pregnant or trying to become pregnant? Last Check up_____
❑	❑	Do you use oral contraceptives? Type_____
❑	❑	Do you use hormone replacement therapy? Type_____

Do you have any of the following skin disorders?

❑ Psoriasis	❑ Dermatitis	❑ Eczema	❑ Keloid Scarring
❑ Fever Blisters	❑ Cold Sores	❑ Sun Blisters	❑ Herpes Simplex/Blisters
❑ Other: _____			

Past Medical History:

[ ] High blood pressure
[ ] Heart disease
[ ] Diabetes
[ ] Hepatitis
[ ] Anemia
[ ] Leg or [ ] Lung blood clots
[ ] Sickle cell
[ ] Blood transfusions
[ ] Stroke
[ ] Bladder infections
[ ] Skin fungus
[ ] Bone fractures
[ ] Breast cancer
[ ] Sleep problems
[ ] Seizures
[ ] Sexually transmitted diseases
[ ] Uterine fibroids
[ ] Abnormal PAP smears
[ ] PMS
[ ] Genital Herpes or blisters
[ ] Oral Herpes or blisters
[ ] Osteoporosis
[ ] Endometriosis
[ ] Pneumonia
[ ] Kidney problems
[ ] PCOS
[ ] Cystic Acne
[ ] Glaucoma
[ ] Liver Disease
[ ] Depression
[ ] Psychiatric problems
[ ] Thyroid disease
[ ] Irritable bowel
[ ] Stomach ulcers
[ ] Arthritis
[ ] Headaches
[ ] Asthma
[ ] Autoimmune (lupus, scleroderma)
[ ] Radiation treatment
[ ] Genital warts
[ ] Constipation
[ ] Skin cancer (type)_____[ ] Other cancer(type)_____
[ ] Other_____

Past Surgeries_____

_____

Do you have any of the following issues?

❑ Uneven skin tone
❑ Enlarged pores
❑ Acne
❑ Upper lip lines
❑ Sun Spots
❑ Sun Damage
❑ Visible exposed blood vessels
❑ Clogged pores
❑ Excessive oiliness
❑ Wrinkles
❑ Dry patches
❑ Brown spots (Hyperpigmentation)
❑ Hard bumps under skin
❑ Blackheads/Whiteheads
❑ Pimples
❑ Scarring
❑ Unwanted Hair
❑ White spots (Hypopigmentation)

What is your skin type: ❑ Dry ❑ Combination ❑ Oily ❑ Normal

Are you currently removing hair by any of the following methods?

❑ Waxing ❑ Tweezing ❑ "Nair" type products ❑ Electrolysis Shaving

❑ Laser Hair Removal When_____ What area?_____ What type of laser?_____

Have you ever had any of the following wrinkle fillers or implants:

❑ Sculptra ❑ Restylane ❑ Perlane ❑ Collagen ❑ Juvaderm ❑ Silicone ❑Radiesse

* If so, when? _____What area? _____By whom? _____

Have you ever undergone any of the following treatments?

❑ Cosmetic Surgery What area of the body?_____
When and where was it done? _____

❑ Acid Peel ❑ Accutane ❑ Microdermabrasion ❑ BOTOX® ❑ Lasers **Which one?** _____

When and where was it done? _____

I certify that the above information is correct to the best of my knowledge. _____
Patient's Signature

Practitioner/MD Notes:

_____

_____

_____

_____