Patient Medical History

Patient_____ Date_____

Date of Birth_____ Occupation_____

Address_____ City _____ State___ Zip_____

Cell Phone_____Home Phone_____

Emergency Contact Name and Phone _____

_____

Medications_____

_____

Have you ever used Accutane for acne treatments?_____

Do you take herbal supplements?_____

Allergies:_____

Have you ever had an allergic reaction to the following: (please circle)

Latex Lidocaine Anesthesia Topical Anesthetic Other_____

Please explain_____

Medical History

Are you under the care of a physician or dermatologist at this time? ❑ Yes ❑ No

Please explain _____

❑ Do you smoke? ❑ Do you drink?

Do you have any of the following medical conditions? ❑ Yes ❑ No

❑ Cardiac Problems (pacemaker or defibrillator)
❑ Bleeding Disorders or Bruise easily
❑ Do you take anticoagulants or aspirin?
❑ Diseases stimulated by light (epilepsy, lupus)
❑ Diseases stimulated by heat (herpes simplex)
❑ Skin disorders or Skin lesions
❑ Hormone imbalance (PCO)
❑ Thyroid
❑ HIV/AIDS
❑ High Blood Pressure
❑ Keloids/scarring
❑ Impaired healing
❑ Cancer
❑ Arthritis
❑ Frequent Cold Sores
❑ Diabetes
❑ Hepatitis
❑ Other medical conditions? Please explain:_____

_____

Female patients: ❑ Are you pregnant? ❑ Are you breastfeeding?

Surgical History
Please list all surgeries_____

_____

IPL/Laser History
Please list treatments_____

_____

Liposuction History
Please list_____

_____

Skin Type
Ethnicity (circle):
White Asian Hispanic Mediterranean Middle Eastern Black Combination

When you go out in the sun do you burn or tan? ❑ Burn ❑ Tan
Are you tan? Yes No (sun tan tanning bed tanning lotions)

Which of the following best describes your skin reaction when you are in the sun?

I. Always burns, never tans
II. Always burns, sometimes tans
III. Sometimes burns, always tans
IV. Rarely burns, always tans
V. Brown, moderately pigmented skin
VI. Black skin

Do you plan to go on a vacation in the near future? ❑ Yes ❑ No

Do you wear sun screen? Never Sometimes Always
What SPF do you wear?_____ How often do you apply your sunscreen? _____
What skin care products do you use? _____

Have you had any of the following injections or fillers? (Please circle)
Collagen Botox Restylane Other_____
Date of last treatment_____

❑ Do you have any tattoos? Location_____

❑ Do you have any tattoo makeup? Location_____

❑ Do you have any beauty marks? Location_____

❑ Do you have any problems with hypopigmentation or hyperpigmentation? Yes No

Location_____

Signature_____ Date_____