MEDICAL HISTORY

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Name: ___________________________________ Gender: ☐ ☐ ☐ ☐

Date of Birth: ________________ Age: _______ Occupation:_______________

Address: ____(Please include Zip Code)

Phone:____________________ Email: __________________________________

Emergency Contact Name and Phone: __________________________________

How did you find us? ____

Describe your skin (circle number):

Do you think you have sensitive skin? **Y** ☐ **N** ☐

I	Always burns, never tans
II	Mostly burns, sometimes tans
III	Sometimes burns, tans gradually
IV	Rarely burns, tans well
V	Brown skin gets darker in the sun
VI	Black skin, never burns

I am interested in the following treatment (s)

- ☐ Laser Hair removal
- ☐ Laser Cellulite reduction (Lipolaser)
- ☐ Laser Skin Tightening
- ☐ Body Contouring (Cavitation-RF-Lipolaser) Triple Fat Burner
- ☐ Teeth Whitening
- ☐ Body Wrap
- ☐ Facials
- ☐ Microneedling
- ☐ Microdermoabration
- ☐ Hydrodermabration
- ☐ Platelet-rich plasma (PRP)
- ☐ Skin Tags

Tanning – Sun exposure: Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

When was the last time you where expose to the sun? ____________________________________

Are you under the regular care of a physician? ______ If yes, why? ____________________________

Please list all previous surgical procedures: ____

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Is there any chance you could be pregnant? **Y** ☐ **N** ☐

Are you Breastfeeding? **Y** ☐ **N** ☐

MEDICAL HISTORY CONTINUED

Do you have any of the following conditions? (Check all that apply):

ANXIETY		LIPOMA	
ARTHRITIS / ARTHROSIS		LUNG DESEASE	
ASTHMA		LUPUS ERYTHOEMATOSUS	
ACNE		MALARIA / PALUDISM	
ACTIVE SKIN INFECTION (eg. psoriasis, eczema)		MIGRAINES / HEADACHES	
ANEMIA		OSTEOPOROSIS	
ALCOHOL ABUSE		PACEMAKER / DEFIBRILATOR	
BLEEDING DISORDER / Burse easily		POLIO	
CANCER		PSYCHIATRIC DISORDERS	
COLERA		ROSACEA	
DISEASES STIMULATED BY LIGHT (eg. Epilepsy-seizures)		SAPHENOUS INSUFFICIENCY	
DISEASES STIMULATED BY HEAT (eg. Herpes simplex)		SEVERE MEDICAL CONDITION (eg. Cardiac)	
DIABETES		SUN / PHOTO-SENSITIVITY	
DRUG ABUSE		SKIN DISORDER: (eg. Keloid, wound healing, ulcers)	
FOLLICULITIS		SMOKING	
GLAUCOMA		SWELLING FEET	
HERPES		TUBERCULOSIS	
HEPATITIS		TUMOR	
HEMOPHILIA		THYROID PROBLEM or Disease	
HISTAMINE (Hives)		VITILIGO DESEASE	
HIGH BLOOD PRESSURE		FACIAL INJECTION (eg.Fillers, Botox)	
HIGH CHOLESTEROL		METAL IMPLANTS	
HIV/AIDS		TANNED SKIN - RECENT	
HORMONE IMBALANCE		NEEDLE EPILATION-WAXING OR TWEEZING IN THE LAST 6 WEEKS	
HYPERPIGMENTATION		TATTOO / PERMANENT MAKEUP	
HYPOPIGMENTATION		FACIAL LASER RESURFACING / CHEMICAL PEEL	
INFECTION OF ANY KINDS		SCARS	
IMMUNE SYSTEM DISORDER		BLOOD TRANSFUSION	
KELOIDS		METAL PINS OR RODS	
KIDNEY / LIVER DESEASE		INPLANTED SILICONE	

Have you ever had an allergic reaction to any of the following? (Check all that apply):

LATEX		ALOE	
ASPIRIN		ANTIBIOTICS (eg. penicillin, sulfa)	
LIDOCAINE / NOVOCAINE		SKIN CREAMS	

List any other allergies: ____

Are you taking any medications? (Please list): ____

(Aspirin, Cortisone, any photosensitive medication such as hormones, steroids, antibiotics, oral contraceptives, any depression or mood-altering drugs such as St. John Wart, etc)

List Over-the-counter medications, vitamins, supplements products: _______________________

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List All Prescription Drugs: ____

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Have you ever used Accutane®? **Y** ☐ **N** ☐ if yes, when did you stop? ____________________

List current skincare products: ____

PANIENT NAME: ______________________PATIENT SIGNATURE: _______________ DATE: ________

SIGNATURES: LASER TECH: _____________________ MEDICAL DIRECTOR: ________________________