

## 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: \_\_\_\_\_