PATIENT INFORMATION AND MEDICAL HISTORY

Patient Name: ________________________________ Date: _______________
Address: _________________ City: ____________ State: ______ Zip: _______
Phone (H): ____________ Phone (C): ____________ Email: _______________
Date of Birth: ____________ Gender: ______________

HISTORY
Please check if you have or have had:

Diabetes	__________	Irregular menses	__________
Hepatitis	__________	Heart problems	__________
Herpes	__________	Hysterectomy	__________
Menopause	__________	Hypertension	__________
Sensitive to anesthetic	__________	Photosensitive Disorder	__________
Lupus	__________	Autoimmune Illness	__________

Are you currently under the care of a physician? ___________________________
Current/Recent Medications: ____

			IF YES, EXPLAIN
Keloid Scars	Yes	No	______________
Hives	Yes	No	______________
Skin Cancer	Yes	No	______________
Waxing	Yes	No	______________
Electrolosis	Yes	No	______________
Cold Sores	Yes	No	______________
Hypersensitivity to skin products	Yes	No	______________
Skin Infections	Yes	No	______________
Tanning in the last 6 wks	Yes	No	______________
Use of acne products/drugs	Yes	No	______________
Laser skin resurfacing	Yes	No	______________
Chemical Peels	Yes	No	______________
Photo sensitizing substances	Yes	No	______________
Laser work of any type	Yes	No	______________

Medical Illness: ____
Are you pregnant? ____
Allergies of ANY kind including drugs: ___________________________________
Areas of interest for aesthetic treatment: _________________________________

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