

PATIENT MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

Email address _____ Can we email you with specials? _____

How were you referred to us? _____

Are you currently under the care of a **primary care physician**? Yes No

If yes, for what _____

Are you currently under the care of a **dermatologist** (skin doctor)? Yes No

If yes, for what _____

Do you have or have you had **any** of the following **medical conditions**? (Please check all that apply)

Cancer _____

Diabetes High Blood Pressure neurological condition Polycystic Ovarian Syndrome

Methomoglobinemia Keloid scarring Skin disease/Skin Lesions Seizure Disorder Hepatitis

Hormone imbalance HIV/AIDS Irregular heart beat Cold sores Thyroid Imbalance

Heart condition (specifically QT prolongation) Arthritis Herpes Blood clotting abnormalities

Active infection Lupus Skin Cancer Abnormal wound healing Very fragile skin

pacemaker or defibrillator permanent implant such as metal plate or screws Liver Problems

Kidney problems Circulation problems Autoimmune Disease

Any additional medical conditions? Please list: _____

Any Past Surgeries? Please list:

Have you ever had an **allergic reaction** to any of the following? (Please check all that apply and describe reaction) Food Latex Aspirin Lidocaine/novocaine/tetracaine/benzocaine

Hydroquinone or skin bleaching agents PABA Others: _____

Reaction: _____

MEDICATIONS

List any medications, herbal supplements, and or vitamins you are presently taking or have taken in the last month: _____

Aspirin Anti-inflammatory medication Birth Control Pills Hormones

Antibiotics Others (Please List) _____

Have you ever used **Accutane**? Yes No If yes, when did you last use it? _____

Have you ever used **Gold Therapy**? Yes No If yes, when did you last use it? _____

What **topical antibiotics, medications or creams** are you currently using or have you used in the past month? Retin A Alpha hydroxy (avoid use within 3 days of treatment)

Others _____

HISTORY

Have you had **light, laser, RF or treatment with another device, chemical peel, dermabrasion, or microdermabrasion to the affected area in last 6 months?**

Details: _____ Yes No

Have you had a **facial surgery or cosmetic injections** within the last year? Yes No

Have you used any of the following **hair removal methods** in the past 6 weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any **sun exposure** or use of any self-tanning lotions within last 2 weeks? (this includes indoor tanning) Yes No

Do you form **keloid scars** (significantly thick or raised)? Yes No

Do you have **hyperpigmentation** (darkening of the skin) or **hypopigmentation** (lightening of the skin) after physical trauma Yes No If yes, please describe: _____

Do you currently smoke? Yes No

How much alcohol usage? Occasional Daily None

Have you had a bone fracture within the last year? Yes No If so which one? _____

For our female patients:

Are you pregnant or trying to become pregnant? Yes No

Are you breastfeeding Yes No

*I certify that the preceding medical, personal and skin history statements are true and correct. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that the success of treatment depends largely on my cooperation with **my treatment schedule and instructions/recommendations** made by the staff. I agree to inform the staff that is treating me of any changes in my skin after treatment, as well as any changes in my overall health.*

Patient Signature _____ Date _____

Staff signature _____ Date _____