

**Patient Medical History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Other Preferred Contact #: \_\_\_\_\_ SSN: \_\_\_\_\_

Do we need to be discrete with appointment scheduling? \_\_\_\_\_ Referred by: \_\_\_\_\_

Area(s) to be treated: \_\_\_\_\_

*Medical History:*

Heart Conditions: \_\_\_\_\_ Keloids: \_\_\_\_\_

Blood Clots: \_\_\_\_\_ Anti-Coagulant: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Cold Sores/Herpes: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Have you taken Accutane or used Gold therapy in the past 6 months? \_\_\_\_\_

Have you had sclerotherapy or any previous laser treatment? \_\_\_\_\_

Please list any antibiotics or medications you are currently taking:

\_\_\_\_\_

Allergies: \_\_\_\_\_

Have you had prolonged sun exposure (or tanning bed) in the last 3 days? \_\_\_\_\_

Are you currently using chemical tanning solutions? \_\_\_\_\_

Check one: (when your skin is exposed to the sun without protection for approximately 1 hour)

- |  |   |
|--|---|
| <input type="checkbox"/> Always burns, never tans                | <input type="checkbox"/> Rarely burns, tans more than average |
| <input type="checkbox"/> Usually burns, never tans               | <input type="checkbox"/> Rarely burns, tans profusely         |
| <input type="checkbox"/> Sometimes mild burn, tans about average | <input type="checkbox"/> Never burns, deeply pigmented        |

Skin Type:	Light	Medium	Dark	Tan
Caucasian . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asian . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mediterranean . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check other services you are interested in:

- Microdermabrasion     Hair removal     Vein Removal     Botox

Other Interest: \_\_\_\_\_

I certify that the above medical history is accurate and correct:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RN/MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_