



PATIENT MEDICAL HISTORY/INFORMATION

Name: _____

What treatments / services are you interested in? (Check all that apply)

___ Laser Hair Reduction ___ Skin Rejuvenation ___ Wrinkle Fillers ___ Botox
___ Chemical Peels ___ Body Contouring/Cellulite Treatments ___ Acne Treatments
___ Skin Care Products ___ Vein Treatment ___ Tattoo Removal ___ Facials

What type of problem are you seeking a consult for? (Check all that apply)

___ Sun Spots ___ Flushing of the skin ___ Wrinkles ___ Hair Removal ___ Cellulite
___ Large Pores ___ Veins ___ Acne ___ Distended blood vessels (red spots that may be spidery in appearance)

How many years have you noticed this problem? _____

At what age did your skin problem occur? _____

Do you feel your skin pigmentation is hormonal related? _____

Why? _____

Are your present skin problems becoming more pronounced? _____

Are you pregnant or planning on a pregnancy soon? _____

What medications are you currently taking, have taken, or used? Last dose taken? _____

___ Aspirin ___ Herbal Preparations* ___ Vitamins ___ Sedatives ___ Insulin
___ Anti-Coagulants ___ Pain Medication ___ Hormones/Contraceptives ___ Cortisone
___ Appetite Depressants ___ Tranquilizer ___ Accutane ___ Rogaine, Minoxidil, or Proscar

Other _____

Do you have a cardiac pacemaker or other implanted metal devices? _____

*If you are taking herbal preparations, what are they? _____

What is your daily consumption of alcohol? _____ Smoking? _____

Do you have a history of:

___ Septicemia (bacterial infection requiring hospitalization) ___ Cold Sores or other herpes infections
___ Bleeding Disorder ___ Diabetes ___ Dark spots after pregnancy ___ (Skin) Cancer
___ Auto Immune Disease ___ Deep Vein Thrombosis ___ Skin Injury (Burns, Ulcers, etc.)
___ Bruising Easily ___ Hormonal or endocrine disorder ___ Immune system depression
___ Keloid Scarring ___ Heart Disease Other _____

Have you had an allergic reaction to anesthesia? ___ Yes ___ No

Have you had allergic reaction to latex? ___ Yes ___ No

Do you have an allergy to the sun? ___ Yes ___ No

Do you have allergies, especially skin related? ___ Yes ___ No

Do you have any allergies to medication? ___ Yes ___ No

If so, please list _____

Reason for visit (area to be treated) _____

Have you ever had skin resurfacing or photo rejuvenation before? ___ Yes ___ No

Have you ever had treatments for pigmented lesions? ___ Yes ___ No

Please list any other treatments, if any _____

Have you ever had vein therapy? ___ Yes ___ No

If so, what kind? _____

Have you ever had electrolysis or laser hair reduction? ___ Yes ___ No

If yes, please list the location and type of treatment _____

Additional Information _____