MEDICAL HISTORY

PRINT NAME: _____________________________ BIRTHDATE: ___/___/___ DATE: __________

MEDICATIONS/HERBS/SUPPLEMENTS____

ALLERGIES: ________________________SENSITIVITIES: ____________________________________

What is your daily consumption of alcohol? __________ Do you smoke or use tobacco? _______________

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please check if yes)

____ History of any atypical moles, skin malignancy or cancer

____ Chronic, inflammatory or irritated skin conditions (i.e., eczema, urticaria, psoriasis, lupus)

____ History of Cold Sore, Fever Blister or Genital Herpes

____ History of any cancer and/or any cancer drug therapy such as Ducabaxine, Fluorouracil, Methotrexate, etc.

____ Active collagen or vascular (blood) disease. If yes, please describe: _______________________

____ History of Post Inflammatory Hyper pigmentation, Keloid Scarring or poor wound healing.

____ Epilepsy ____ High blood pressure ____ Diabetes (insulin dependent)

____ Hypothyroidism ____Coronary artery disease ____ Kidney Disease Systemic Lupus

____ Pregnant or breastfeeding

____ Do you have any autoimmune conditions such as connective or collagen disorders and immune compromised.

Yes ___ No____ If yes please list: ____

____ Phlebitis, thrombophlebitis, bleeding or clotting disorders or use anticoagulants medications

____ Pacemaker or automated implantable cardioverter defibrillator (AICD)

____ Acne ____ Taken Isotretinoin (Accutane) w/in last 6 months, Tretinoin (Retin A) w/in last 2 weeks

____Taken St. John's Wort or photosensitizing antibiotics or other medications within last 3 months

____Large dental metallic prosthetic implants or metal implants or hardware or wear contact lenses

____Cosmetic Procedures or Surgeries. Please list: ____

____Current infection of any kind. If yes, please describe: _______________________________________

____ Prolonged sun exposure or tanning or self-tan product use within the last 3-4 weeks

____Recent skin treatments, chemical peels, or abrasion treatments

**Patient Initials* ________________

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Photographs: Photographs are required for documentation purposes and complete confidentiality will be maintained. I consent to taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion, including the internet. Please check one: yes_____ or no____ and initial_____.

SKIN TYPING

Please check what applies to you as it relates to the next question.

What happens to your skin, when exposed to sun without protection for an hour:

___Always burn, never tans

___Always burn, sometimes tans

___Sometimes burn, sometimes tans

___Always tans

What is your heritage? *Please circle if applies*: Hispanic, Native American, Mediterranean, Middle Eastern, African American, other ______________________

What is your current skincare regime? ____

____

What is your plan for aging well? ____

What bothers you most about your skin? ____

REASON FOR VISIT: ____

Circle the services you'd like to learn about: *Feminine Rejuvenation *Hormone Replacement *Weight Loss *Fat Reduction *Body Sculpting *Skin Tightening *Latisse *Botox *Fillers *Tattoo removal *Skincare Products *Skincare advice *Chemical Peels *Laser Rejuvenation *Brown Spots *Spider Veins *Rosacea or Acne Treatment * Laser Toe Nail Fungus Treatment *Laser Hair Removal *Family Practice Services

Is there anything else you'd like to learn more about? ____

Patient **Signature**: __________________________________ Date: _____________________

Medical Aesthetician Signature: _______________________ Date: _____________________

Reviewed by Provider: __________________________Clearance for Laser and Skin Treatments and Products; Tretinoin <.00, HQ 4%_______ Initial