Family Health & Beauty

MEDICAL LASER & SKIN SERVICES

Patient:_____Date of Birth: _____/_____/_____

Address:_____

Phone:_____ Cell Phone: _____

Email:_____

How did you hear about our Office?_____

Reason for Consultation: _____

Do you currently have a primary care physician? ( ) NO ( ) YES
If yes, please list:_____

List all medications your are currently taking (include prescriptions, over-the-counter meds, & herbs):_____
_____
_____

Do any of your medications prohibit exposure to sun or light (cause photosensitivity)? ( ) NO ( ) YES

Have you been on Accutane in the past 6 months? ( ) NO ( ) YES

Have you undergone chemotherapy or radiation? ( ) NO ( ) YES

Do you experience herpes or cold sore breakouts? ( ) NO ( ) YES

Do you take aspirin, ibuprofen, vitamin E, or other blood-thinning medication?
_____

List all the Medical conditions
_____

Do you get redness/darkness from scars: ( ) NO ( ) YES

Have you had skin cancer? ( ) NO ( ) YES If yes, please list_____

Do you wear sunscreen daily? ( ) NO ( ) YES If yes, please list_____

Do you have any specific skin diseases? ( ) NO ( ) YES
If yes, please list_____

Do you have problems with healing? ( ) NO ( ) YES

Have you had blistering sunburns? ( ) NO ( ) YES

Do you develop keloids (raised bumpy scars)? ( ) NO ( ) YES

Do you bleed easily? ( ) NO ( ) YES

Do you smoke cigarettes ( ) NO ( ) YES

Please disclose any minimally invasive cosmetic procedures (Botox, fillers, laser Rx) you had: _____

Please list any additional concerns or questions you have regarding your skin or any aesthetic issues _____

Thank you for taking your time to answer all of the above questions. We appreciate you providing all of your personal medical information in order to give you a proper and accurate assessment of your skin's aesthetic needs.

PATIENT SIGNATURE _____

PATIENT NAME _____Date_____

Reviewers Signature _____Date_____