EXPERTS IN BEAUTIFUL SKIN

LASER Esthetica

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MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Have you ever had the following:

- ❑ Rosacea
- ❑ Bleeding Disorder
- ❑ Cold Sores
- ❑ Keloid Scar Formation
- ❑ Sun Sensitivity
- ❑ Allergies (please list): _____
- ❑ Past Medical Illness (please list): _____
- ❑ Past Surgeries (please list): _____

Medications/Medical Treatment:

Are you currently taking birth control pills?	❑ Yes	❑ No
Are you currently pregnant or breast feeding?	❑ Yes	❑ No
Are you planning on getting pregnant in the near future?	❑ Yes	❑ No
Have you ever taken Accutane?	❑ Yes	❑ No
Do you use any Acne Medication?	❑ Yes	❑ No

If Yes, please list: _____

Other Prescription Medications (including herbal): _____

Over the Counter Medications (including herbal): _____

Are you presently under a physician's care for any condition? If so, please describe:

_____

Lifestyle Information:

Do you consume alcohol?	❑ Yes	❑ No
Do you smoke?	❑ Yes	❑ No
Do you exercise regularly?	❑ Yes	❑ No
Do you use tanning booths?	❑ Yes	❑ No

Describe your history of sun exposure: _____

Skin Type (Check all that apply):

- ❑ Sunburn easily
- ❑ Usually tan
- ❑ Sensitive
- ❑ Dry
- ❑ Sunburn, then tan
- ❑ Always tan
- ❑ Oily
- ❑ Normal

Cosmetic History (Check all that apply):

- ❑ Facial surgery
- ❑ Botox injections
- ❑ Filler injections
- ❑ Facial peels
- ❑ Laser Treatments (please list):_____

Personal Comments: _____

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