PATIENT MEDICAL HISTORY

Patient Name:_____ **DOB:**_____

Address:_____

Phone Number:_____

Email address: _____ Can we email you with specials?_____

How were you referred to us?_____

Are you currently under the care of a **primary care physician**? Yes No
If yes, for what_____

Are you currently under the care of a **dermatologist** (skin doctor)? Yes No
If yes, for what_____

Do you have or have you had **any** of the following **medical conditions**? (Please check all that apply)
Cancer _____

Diabetes Diabetic neuropathy neurological condition numbness, tingling, nerve pain
Seizure Disorder

Skin disease/Skin Lesions Very fragile skin Cold sores Diastasis Recti
Active infection Abnormal wound healing Skin Cancer Herpes

Thyroid Imbalance Polycystic Ovarian Syndrome Blood clotting/bleeding abnormalities
Circulation problems

Heart condition (specifically QT prolongation) Methomoglobinemia
pacemaker or defibrillator permanent implant such as metal plate or screws Irregular heart beat

Lupus Autoimmune Disease Liver Problems Hepatitis Kidney problems
Past or present hernia HIV/AIDS

Any additional medical conditions? Please list:_____

Any Surgeries? Please list with dates:
_____
_____
_____

Have you ever had an **allergic reaction/sensitivity** to any of the following? Latex Aspirin Rubbing alcohol Propylene glycol Lidocaine/novocaine/tetracaine/benzocaine Hydroquinone or skin bleaching agents PABA Others:_____

MEDICATIONS

List any medications, **herbal supplements**, and or **vitamins** you are presently taking or have taken in the last month:_____
_____

Aspirin Anti-inflammatory medication Birth Control Pills
Antibiotics Blood thinning medication Others (Please List)_____

Have you ever used **Accutane**? Yes No If yes, when did you last use it?_____
Have you ever used **Gold Therapy**? Yes No If yes, when did you last use it?_____

What topical antibiotics, medications or creams are you currently using or have you used in the past month? Retin A Alpha hydroxy
Others_____

HISTORY

Have you had **light, laser, RF or treatment with another device, chemical peel, dermabrasion, or microdermabrasion to the affected area in last 6 months**?
Details:_____ Yes No

Have you had a **facial surgery or cosmetic injections** within the last year? Yes No

Have you used any of the following **hair removal methods** in the past 6 weeks?
Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any **sun exposure** or use of any self-tanning lotions within last 2 weeks? (this includes indoor tanning) Yes No

Do you form **keloid scars** (significantly thick or raised)? Yes No

Do you have **hyperpigmentation** (darkening of the skin) or **hypopigmentation** (lightening of the skin) after physical trauma Yes No If yes, please describe:_____

Do you currently smoke? Yes No

For our female patients:
Are you pregnant or trying to become pregnant? Yes No
Are you breastfeeding Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand that the success of treatment depends largely on my cooperation with **my treatment schedule and instructions/recommendations** made by the staff. I agree to inform the staff that is treating me of any changes in my skin after treatment, as well as any changes in my overall health.

Patient Signature_____ Date_____

Staff signature _____ Date _____

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