Personal Profile and History

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

City/ State/ Zip:_____

Date of Birth:_____/_____/_____ Age:_____ Gender:M_____F____

Occupation:_____ Email address:_____

How did you hear about us? _____

Which areas would you like to consider for laser treatments? _____

_____

_____

Please share any questions, concern or comments: _____

_____

_____

Females: are you pregnant? □ Yes □ No Are you Breastfeeding? □ Yes □ No

Are you planning pregnancy during the course of your treatment? □ Yes □ No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:

□ African American □ Asian □ Caucasian □ Hispanic □ Mediterranean

□ Middle Eastern □ Native American □ Other:_____

Please complete the following items of medical history. Please, always inform us of any changes in your medical history and/or medications.

Please list **all** medications including prescription and over the counter drugs, vitamins,

herbs, supplements: _____

_____

_____

_____

Are you allergic to any medications? □ Yes □ No Please list medications and reactions.

_____

_____

Medical History: Please check all that apply

□ Acne
□ Bleeding disorder
□ Burns / skin grafts
□ Diabetes
□ Endocrine disorders
□ Epidermolysis Bullosa
□ Gold therapy
□ Heart disease
□ Hemorrhoids
□ Herpes
□ High blood pressure
□ Hirsutism
□ Hormone Replacement Rx
□ Implants
□ Kaposi's sarcoma
□ Keloid scars
□ Lupus erythematosus
□ Permanent makeup
□ Polycystic ovary disease
□ Port-wine stain
□ Precocious Puberty
□ Psoriasis
□ Seizures
□ Shingles
□ Skin cancer
□ Tattoos
□ Thyroid disease
□ Vitiligo

□ Other? _____

□ Surgery in the area to be treated? _____

Personal Profile and Health History (continued)

If the answer to any of the following questions is yes, please details in the space provided.

1. Are you currently being treated for any medical conditions? Yes No

   Explain: _____

2. Have you used Accutane in the last 6 months? How recently? _____ Yes No
3. Do you have any active skin diseases or infection in the area to be treated? Yes No
4. Do you have any skin allergies? Yes No
5. Are you allergic to latex, lidocaine, or any lotions? Please circle any that Apply. Yes No
6. Are you currently using glycolic acid or Retin A? Please circle any that Apply. Yes No
7. Have you had a chemical peel or facial within the last week? Yes No
8. What products are you currently using on your skin?

   Describe: _____
9. Have you had any permanent cosmetic tattooing to the area to be treated? Yes No

10. Do you have any metal or other implants? Where? _____ Yes No
11. Have you had any previous laser treatment or other skin treatment to the Area to be treated? Yes No

    Describe: _____
12. Are there any moles in the area to be treated? Yes No
13. Are you currently using or have you used within the last six weeks a tanning Bed or tanning cream? If yes, date of last use ___/____/____. Yes No
14. Have you been exposed to the sun within the last four to six weeks? Yes No
    If yes, approximate date of last exposure _____/_____/_____.

Name of your family doctor: _____ Phone #: _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: _____ Date:____/____/_____

Signature of Consultant: _____ Date: ____/____/_____

Doctor Review: _____ Date: ____/____/_____