LASER REJUVENATION

MEDICAL & PERSONAL HISTORY

Name: _____ Date: _____

Drivers License #: _____ Birth Date (mm/ dd/ yyyy): ____/ ____/ _____

Address: _____ City: _____ St: ____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

E-mail Address: _____

Sex: _____ Ethnicity: _____

Emergency Contact: _____ Phone: _____

Main reason for today's visit: _____

Other Concerns: _____

MEDICATIONS: Prescription and non – prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	**Dose (e.g., mg/pill)**	**Reason for Each**

PERSONAL MEDICAL HISTORY: Please indicate whether you currently have or have had any of the following medical conditions (with dates).

- ☐ Acne
- ☐ Auto-Immune Disease
- ☐ Cardiac Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy/Seizure Disorder
- ☐ Recent Fever/Cold/Flu
- ☐ Gastrointestinal
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidney Disorders
- ☐ Liver Disorders
- ☐ Lymphatic Disorders
- ☐ Lipomas (Fatty Tumors)
- ☐ Neurological
- ☐ Organ Transplant
- ☐ Psychiatric
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Skin Conditions (i.e. rash, sensitivity)
- ☐ HSV 1 or HSV 2 (herpes virus)
- ☐ Keloid/Hypertrophic scars

If you have checked any of the boxes in the Personal Medical History section, please describe what steps you have taken to treat these conditions:

_____

_____

_____

_____

_____

List dosage of oral antibiotics/Accutane and date of last dose taken: _____

List any topical medications you are using: _____

Allergies or reactions to medications and/or creams, environmental and foods:

_____

_____

_____

SURGICAL HISTORY: Please list all prior operations (with dates):

_____

_____

_____

_____

1. As a result of any surgeries, do you have any metal implants? **YES / NO**

2. Do you have any open wounds or present burns in the area to be treated? **YES / NO**

3. Do you have any numbness, both superficially and deeply in the area you are requesting treatments? (This is very important, because patient feedback is necessary to achieve safe and effective results.) **YES / NO**

4. Do you currently have any electrical support systems in you body (i.e. pacemakers, automatic defibrillator, cardioverter)? **YES / NO**

If yes, please list: _____

5. Have you had any other type of implantable devices? **YES / NO**

If yes, please list: _____

COSMETIC HISTORY:

1. Have you had any cosmetic procedures in the area you are seeking treatment? **YES / NO**
    a. If yes, please explain: _____
2. Have you had any complications as a result of any cosmetic procedure(s): **YES / NO**
    a. If yes, please explain: _____
3. Have you recently had any Botox or soft tissue fillers (i.e. Restylane, Juvederm) in the area you are currently requesting treatment? **YES / NO**
    a. If yes, when was the date of you last treatment(s)? _____
4. Do you have any permanent make – up? **YES / NO**
    a. If yes, please list locations: _____
5. Please list previous laser treatment(s): (specify date, # of treatments, frequency, devise used and tissue reaction; if known):

    _____

    _____

    _____

    _____

6. Previous Hair Removal History, if applicable: **Wax _____ Plucking _____ Electrolysis ____ Bleaching _____ Shaving _____**
    a. Frequency & Last use of above modalities:

        _____
7. Have you had a facial, microdermabrasion, chemical peel? **YES / NO**
    a. If yes, please explain:

        _____

        _____
8. Please list the skincare products you are currently using:
    a. Cleanser: _____
    b. Toner: _____
    c. Scrubs: _____
    d. Moisturizer: _____
    e. Sun protection: _____
9. Please list tattoos and the location of each:

    _____

    _____

PREGNANCY & CONTRACEPTIVES:

1. Are you currently menstruating? **YES / NO**
2. If you are a woman, are you currently pregnant, or is there a chance you are pregnant? **YES / NO**
3. Are you currently trying to get pregnant? **YES / NO**
4. Are you currently on birth control? **YES / NO**
5. Are you currently breast feeding? **YES / NO** If yes, please list: _____
6. If you have delivered a child, what type of delivery did you have? **Cesarean Section / Vaginal**
7. Do you have a Tubal Ligation? **YES / NO**
8. If you have had tubal ligation, what material is your clip made of? **Titanium / Plastic**
9. Do you have and IUD? **YES / NO**
10. If yes, which of the following material does it contain? **Copper / Hormones**

SOCIAL HISTORY:

1. Are you currently using or do you have a history of tobacco use? **YES / NO**
2. If yes, please list: packs/day _____ Other: _____ # of Years: _____
3. Are you currently using or do you have a history of illegal drug use? **YES / NO**
4. Please describe you alcohol consumption:

   Daily / Weekly / Monthly/ Occasionally / Rarely / Never
5. Please describe your caffeine intake: **None / Coffee / Tea / Soda** **_____ cups/day**
6. Please describe your tanning history: **Direct Sun / Tanning Bed / Self Tanners / Spray Tans**

   Date of Last use: _____

OTHER:

Are you being treated for any other conditions not listed? If so, please explain:

_____

_____

_____

Is there any other information that you feel may be related to or is pertinent to your treatment? If so, please explain:

_____

_____

_____ _____

(Patient Signature) **(Date)**