LASER SKIN
& WELLNESS CENTER

HEALTH HISTORY INFORMATION

Name: ____ Date: ____________

Last First MI

Street Address: ____

City: ____ State: ______________

Zip: _______________

Date of Birth: _______________________________ Age: _____________

Sex: ☐ Female ☐ Male

Home Phone: ________________________ Cell Phone: ________________________

Leave Messages At: ☐ Home ☐ Cell Other: ___________________________

Email Address: ____

Stay updated on services, promotions, and discounts? ☐ Yes ☐ No

Primary Care Physician: ____

How were you referred to us? ____

Emergency Contact:

Name: _______________________________ Phone: _______________________

Relationship: ___________________________________

Do we have permission to communicate changes in your health status, including surgery, to other physicians participating in your care?

☐ Yes, May Notify ☐ No, Please Do Not Notify

Do you have any major medical problems or serious illness? ☐ Yes ☐ No

If so, please list:

____

____

Please list all prior surgical procedures and dates performed:

____

____

____

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Please list all injectable procedures (Botox, Restylane, Collagen, etc…) and dates they were performed:

____

____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? ☐ Yes ☐ No

Do you have a history of easy/ excessive Hyperpigmentation? ☐ Yes ☐ No

Do you form keloid scars? ☐ Yes ☐ No

Do you suffer from seizures? ☐ Yes ☐ No

Do you have metal implants? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Have you taken Accutane, Retin A or Renova in the past 6 months? ☐ Yes ☐ No

Are you currently taking Coumadin (Warfarin) or other blood thinners? ☐ Yes ☐ No

Do you require antibiotics before procedures such as dental cleanings? ☐ Yes ☐ No

Do you use medicinal/ recreational marijuana? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, quantity per week? _________________

Have you ever had an adverse reaction to laser or cosmetic treatments?

☐ Yes ☐ No If so, please list:

____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

____

Do you have any other allergies? ☐ Yes ☐ No If yes, please list:

____

____

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Have you ever had or do you have any of the following (please check):

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Blood Clotting Abnormalities
- ☐ Keloid Scarring
- ☐ Circulation Problems
- ☐ Cold Sores / Shingles
- ☐ Collagen Disorder
- ☐ Diabetes (Type _____)
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Endocrine / Hormonal Issues
- ☐ Eye Problems
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV / AIDS
- ☐ Hormonal Imbalance
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms
- ☐ Herpes
- ☐ Cancer
- ☐ Neurological Disorders
- ☐ Permanent Makeup / Tattoos
- ☐ Pigmentation Disorders
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Recent Surgery
- ☐ Scleroderm
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Skin Injury
- ☐ Stroke
- ☐ Unusual Moles
- ☐ Varicose Veins
- ☐ Vision Deficits

Do you have any other problems or medical conditions? Please list: ______________________

____

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Do you take any of the following (Please Check):

- ☐ Antibiotics
- ☐ Anti-Coagulants
- ☐ Anti-Depressants
- ☐ Appetite Depressants
- ☐ Aspirin/ Ibuprofen
- ☐ Blood Pressure Medication
- ☐ Cortisone or Steroids
- ☐ Hormones / Constraceptives
- ☐ Insulin
- ☐ NSAIDS
- ☐ Sedatives
- ☐ Thyroid Medication
- ☐ Other: ___________________
- ☐ Other: ___________________

Are you taking herbal preparations or vitamins (St. John's Wort, Vit. E, etc)?

☐ Yes ☐ No

Are you or might you be pregnant? ☐ Yes ☐ No ☐ N/A

Are you trying to become pregnant? ☐ Yes ☐ No ☐ N/A

Are you nursing? ☐ Yes ☐ No ☐ N/A

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SKIN CARE HISTORY & CONCERNS

Please list any products that irritate your skin:

____

____

Have you had unprotected sun exposure or been in a tanning booth in the last 2 weeks?

☐ Yes ☐ No

Do you use self -tanners? ☐ Yes ☐ No

Are you planning a vacation in the sun in the next 3-4 months? ☐ Yes ☐ No

Have you used any of the following hair removal methods in the past 6 weeks?

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking/ Tweezing ☐ Stringing ☐ Depilatories

Please indicate your current skin care products/ regimen:

____

____

____

____

MY SPECIFIC SKIN & BODY CONCERNS/ INTERESTS

Please check all that apply to you:

☐ Skin Discoloration
☐ Thin Lips
☐ Brown Spots
☐ Acne
☐ Crow's Feet
☐ Rosacea
☐ Fine Wrinkles
☐ Deep Wrinkles
☐ Excess Fat/ Weight
☐ Deep Lines around the Mouth
☐ Marionette Lines
☐ Thinning Hair
☐ Loose Skin
☐ Lip Lines
☐ Excessive Sweating
☐ Dry/ Oily Skin
☐ Scars
☐ Facial Veins

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☐ Facial/ Body Hair ☐ Leg Veins

☐ Not Certain ☐ Other: ____________________

List any prior treatments and approximate date. (Accutane, Botox, Peels, IPL, Lasers, Surgery, etc...)

Treatment: __________________________________ Date: ________________

Treatment: __________________________________ Date: ________________

Treatment: __________________________________ Date: ________________

Have you ever used Accutane? ☐ Yes ☐ No

If so, when was your last dose? _________________

SIGNATURE

I certify that the preceding medical, medication, and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature: ____ Date: ________________

I have been informed of payment policies. I understand that pre-payment iis required for all cosmetic and body sculpting services and that I am financially responsible for all procedures. I understand that there is no refund for prepaid services. Your signature below signifies your understanding and willingness to comply with this policy.

Client Signature: ____ Date: _______________