Esthetic / Laser / Product- Medical History Form

Name ____ Date _______________
DOB ______________

1. What is the purpose of your visit today? ____
2. What results do you wish to have? ____
3. Have you recently or are you currently having any other facial or complexion treatments? ❑ yes ❑ no
4. What type of facial products do you use? ____
5. Do you drink caffeine? ❑ yes ❑ no How much per day? ________________
6. Do you drink water? ❑ yes ❑ no How much per day? ________________
7. Do you use sunscreen daily? ❑ yes ❑ no What SPF? ____ Face only ❑ All over❑
8. Do you wear contact lenses? ❑ yes ❑ no
9. Are you currently using tanning beds? ❑ yes ❑ no
   If yes, have you tanned in the last 30 days? ❑ yes ❑ no
10. Do you use facial waxing or depilatories? ❑ yes ❑ no
    If yes, when was your last treatment? ________________________________
11. Do you have acne or an occasional breakout? ❑ yes ❑ no
12. Are you currently seeing a doctor for acne? ❑ yes ❑ no
13. Are you using acne or other topical facial medications?❑ yes❑ no
14. Are you currently using any medications? ❑ yes ❑ no
    List all medications you are currently using: ____
    ____
    List any medication you have discontinued within the last 30 days: ______________________
    ____
    Are any of the above listed medications ones that make you sensitive to the sun: ___________
    ____
15. Are you allergic to any medications? ❑ yes ❑ no
    If yes, please list: ____
16. What is your skin type? ❑ normal to dry ❑ normal to oily ❑ combination
    (If combination please describe): ____

1. Are you using Retin-A, Renova or any tretinoin product? ❑ yes ❑ no
2. Do you have a history of allergies to cosmetics? ❑ yes ❑ no
   List ingredients to which you are allergic: ______________________________________
3. Do you have a history of keloids or pigmented scarring? ❑ yes ❑ no
4. Do you have a history of seborrhea, rosacea or other facial rash? ❑ yes ❑ no
5. Have you had any laser, radiation, cryosurgery, electrosurgery, or injection treatments in the past six months? ❑ yes ❑ no
6. Do you have a history of Dysplastic Nevi or Malignant Melanoma In the area you wish treated? ❑ yes ❑ no

"Yes" to any of the above questions may indicate the possibility of skin sensitivity/reaction.

1. Do you have an autoimmune disease (such as lupus)? ❑ yes ❑ no
2. Do you smoke? ❑ yes ❑ no
3. Do you drink alcohol? ❑ yes ❑ no

"Yes" to any of the above questions may indicate slow healing.

-OVER-

1. Have you taken Accutane within the past six months? ❑ yes ❑ no
2. Do you currently have any warts in any area that you wish treated? ❑ yes ❑ no
3. Do you have epilepsy? ❑ yes ❑ no
4. Do you have any hormonal imbalances? ❑ yes ❑ no
5. Do you have a history of herpes simplex? (fever blisters/cold sores) ❑ yes ❑ no
6. Do you have a history of genital herpes? ❑ yes ❑ no
7. Are you currently pregnant or breast feeding? ❑ yes ❑ no
8. Do you have HIV, or been exposed to it? ❑ yes ❑ no
9. Do you have Hepatitis, or been exposed to it? ❑ yes ❑ no
10. Do you have any tattoos in the areas you would like treated? ❑ yes ❑ no
11. Do you have any beauty marks that you want to keep in the areas that you want treated? ❑ yes ❑ no
12. Do you currently have a sunburn, or any cuts or abrasions in the areas to be treated? ❑ yes ❑ no
13. Circle one of the following statements as it relates to your skin:
    I. Always burn, never tan
    II. Always burn, sometimes tan
    III. Sometimes burn, sometimes tan
    IV. Rarely burn, tan with ease
    V. Moderately pigmented, always tan
    VI. Deeply pigmented, never burn

"Yes" to any of the above questions may indicate certain procedures should not be done at this time.

Patient's Signature: ______________________________ **Date** ____________
(Or legal guardian)

Patient's Name: ______________________________________

Legal guardian's name: ______________________________________

Reviewed by: ______________________________ **Date** ____________

The following should only be answered if you are a female interested in hair removal

Please check all that apply:
❑ yes ❑ no Acne that is unresponsive to treatment
❑ yes ❑ no Obesity
❑ yes ❑ no Irregular or painful menses
❑ yes ❑ no History of excess hair in female members of your family
❑ yes ❑ no Hair loss/thinning of scalp hair
❑ yes ❑ no Excessive hair growth in/on belly button, chin, chest and or lip

Patient's Signature: ______________________________ **Date** ____________
(Or legal guardian)

Patient's Name: ______________________________________

Legal guardian's name: ______________________________________

Reviewed by: ______________________________ **Date** ____________

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