



Laser and Aesthetic Center
Medical History

Name: _____

Address: _____

Home Phone: _____ Business Phone: _____

Date of Birth: _____ Social Security Number: _____

Have you ever suffered from the following?

Diabetes: [] Yes [] No Bleeding Disorder: [] Yes [] No

Are you Pregnant? [] Yes [] No

What medications are you taking (including aspirin)? _____

What is your daily consumption of alcohol? _____

Allergies: _____

Are you taking herbal preparations? (St. John's Wart) [] Yes [] No

If yes, list _____

Do you wear contact lenses? [] Yes [] No

Mark your skin type (when exposed to the sun without protection for about 1 hour)

- I. Always burns, never tans []
II. Always burns, sometimes tans []
III. Sometimes burns, sometimes tans []
IV. Always tans []
V. Hispanic, Asian, Mediterranean, Middle East []
VI. Black []

When were you last exposed to the sun (including tanning booth)? _____

Do you use chemical sun tanning lotions? [] Yes [] No

Are you planning a holiday in the sun? [] Yes [] No

Area you are interested in having treated: _____

Have you ever had electrolysis before? [] Yes [] No

If yes, location: _____

Prior Treatment (if any): _____

Have you ever had skin resurfacing or photorejuvenation before? [] Yes [] No

Have you ever had vein therapy? [] Yes [] No;

If yes, location: _____