MEDICAL HISTORY FORM (Laser/IPL)

Date:_____

First Name: _____ Last Name: _____

E-mail: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Emergency Contact: _____ Phone: _____

What treatment/(s) are you interested in? Please circle: Improvement in red/brown spots, scars, stretch marks, texture, tone, hair removal, fine lines and wrinkles What body area?

_____
_____

Please answer all of the following questions:

1. Do you have ANY current or chronic medical illnesses? Please disclose any history of heat urticaria, diabetes, autoimmune disorders (such as lupus) or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness. Please List:

_____
_____
_____

2. Do you have ANY current or chronic skin conditions? Also disclose any history of vitiligo, eczema, lupus, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition. Please List:

_____
_____
_____

3. Are you currently under a doctor's care? If so, for what reason?

_____
_____

4. Do you take/use ANY medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List:

_____
_____

5. Are there any topical products (both prescription and non-prescription) that you use on your skin on a regular or daily basis? Please List:

_____
_____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?

_____

7. Do you have ANY allergies to medications, foods, latex or other substances? Please List:

_____
_____

8. (For women) Are you or could you be pregnant/breastfeeding?

_____

9. (For women) Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Syndrome?

_____

10. Do you have a history of herpes or cold sores in the area to be treated?

_____

11. Do you have a history of keloid scarring or hypertrophic scar formation?

_____

12. Do you have a history of light induced seizures?

_____

13. Do you have any open sores or lesions?

_____

14. Do you have any history of radiation therapy in the area to be treated?

_____

15. In the last 2-4 weeks, have you used any of the following: anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatory medications? Please list medications and the date last used:

_____
_____

16. In the last month, have you used any of the following products: glycolic acid or any acid products; exfoliating, resurfacing products, chemical peels or treatments? Please list product name and date last used:

_____
_____

17. Do you have or have you ever had any permanent make-up, tattoos, implants, fillers, including, but not limited to Juvederm®, Voluma®, Restylane®, Radiesse®, Perlane®, Bellafill®, Artefill®, Sculptra®, collagen, etc.? If yes, please list areas treated and dates:

_____
_____

18. Do you currently have or have you ever had any botulinum toxins such as Botox®, Xeomin® or Dysport®? If yes, please list areas treated and dates:

_____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 6 months? in the last month?®, Tazorac ®, Tretinoin, Renova®

_____

20. Have you used any retinoids/retinols (like Retin-A)

_____

21. Have you had any sun exposure, used tanning creams (including, sunless tanning lotions) or tanning beds in the last 4 weeks?

_____
_____

Signature: _____

Date: _____

FITZPATRICK SKIN TYPE WORKSHEET

Name: | Date:

SCORE		0	1	2	3	4
	What is the color of your eyes?	Light Blue, Gray or Green	Blue, Gray, or Green	Blue	Dark Brown	Brownish Black
	What is your natural hair color?	Sandy red	Blond	Chestnut Dark Blond	Dark Brown	Black
	What is the color of your exposed skin?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have Freckles on Sun exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful Redness, Blistering, Peeling	Blistering Followed	Burns sometimes followed by Peeling	Rarely Burns	Never burns
	To what degree do you turn brown?	Hardly or Not at all	Light Color Tan	Reasonable Tan	Tan Very Easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the Sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to tanning beds or self-tanning creams?	More than 3 months ago	2-3 Months ago	1-2 Months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always

TOTAL SCORE						
	SCORE	0-7	8-16	17-25	26-30	Over 30
	FITZPATRICK SKIN TYPE	I	II	III	IV	V-VI

For office use only, do not fill out TOTAL SCORE.

What is your ethnic background?

Notes:

DQ-FORM-02