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|  | **Medical Historyfor Laser / BBL™ Skin Procedures** |

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| --- |
| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone #1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Phone #2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Female** **[ ]  Male** **[ ]**  | **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Reason for consultation**

[ ]  Acne

[ ]  Brown spots or sun damage

[ ]  Enlarged blood vessels

[ ]  Fine lines or wrinkles

[ ]  Flushing of the skin

[ ]  Skin laxity

[ ]  Skin texture or scars

[ ]  Unwanted hair

**Questions about skin**

1. How long have you been concerned about this area(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. At what age did you notice this concern(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are your present skin concern(s) getting more pronounced? [ ]  Yes [ ]  No
4. Have you ever been treated for this concern(s)? [ ]  Yes [ ]  No

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking medication for your skin’s concern(s)? [ ]  Yes [ ]  No

 If yes, what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What topical skin medications or products are you currently taking?

 [ ]  Retin-A® [ ]  Hydroquinone or bleaching agent [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had laser / IPL hair removal? [ ]  Yes [ ]  No
2. Have you ever used the following hair removal methods in the past 6 weeks?

 [ ]  shaving [ ]  waxing [ ]  electrolysis [ ]  plucking/tweezing [ ]  stringing [ ]  depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels? [ ]  Yes [ ]  No

10. Have you ever had treatments for pigmented lesions? [ ]  Yes [ ]  No

11. Do you form thick or raised scars (keloids) from cut or burns? [ ]  Yes [ ]  No

12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? [ ]  Yes [ ]  No

13. Have you had cold sores or fever blisters? [ ]  Yes [ ]  No

**Skin Type choices (when exposed to the sun for about 1 hour with no protection):**

* Always burns, never tans [ ]
* Always burns, sometimes tans [ ]
* Sometimes burns, always tans [ ]
* Rarely, burns, always tans [ ]
* Brown, moderately pigmented skin [ ]
* Black skin [ ]
1. When were you last exposed to the sun or tanning booth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you use self tanners? [ ]  Yes [ ]  No
3. Are you planning a vacation in the sun? [ ]  Yes [ ]  No

**Personal history:**

1. Do you smoke? [ ]  Yes [ ]  No if yes \_\_\_\_\_\_ packs per day
2. What is your weekly consumption of alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you wear contact lenses? [ ]  Yes [ ]  No

**Medical history:**

1. Are you currently under the care of a physician? [ ]  Yes [ ]  No. If yes, for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any of the following?

[ ]  Arthritis

[ ]  Any active infection

[ ]  Bleeding disorders

[ ]  Bruising

[ ]  Dark spots of pregnancy

[ ]  Diabetes

[ ]  Epilepsy or seizures

[ ]  Heart disease

[ ]  Hepatitis

[ ]  Herpes simplex

[ ]  High blood pressure

[ ]  Hormone imbalance

[ ]  HIV / Aids

[ ]  MRSA

[ ]  Sensitive teeth

[ ]  Skin cancer or moles

[ ]  Skin injury

[ ]  Vision deficits

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you have allergies to any of the following? (check all that apply) [ ]  medications [ ]  latex

 [ ]  anesthesia [ ]  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you take any of the following?

[ ]  Accutane

[ ]  Antibiotics

[ ]  Anti-coagulants

[ ]  Anti-depressants

[ ]  Appetite depressants

[ ]  Aspirin or Ibuprofen

[ ]  Cortisone or steroids

[ ]  Hormone/contraceptives

[ ]  Insulin

[ ]  Sedatives

[ ]  Thyroid medication

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_

5. Are you taking herbal preparations or vitamins? (St. John’s Wort, Vitamin E) [ ]  Yes [ ]  No
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For female patients:**

1. Are you pregnant or trying to become pregnant? [ ]  Yes [ ]  No

*I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_