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|  | **Medical History for 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_