

Patient Information Profile

Patient Name _____ Date: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____

Occupation: _____ E-mail _____

Employment Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

May we contact you at work: _____

Emergency Contact: _____ Telephone: _____

Purpose of Consultation:

Referred By: (Please check one of the following :)

Postcard: _____ Brochure: _____ Internet: _____ Yelp: _____ Friend: _____ Dr. _____

Other: _____

(Friend's Name) _____

Medical Evaluation Form

Medical History:

Are you pregnant? _____ Yes _____ No

Date of last Menstrual period: _____ / _____

Do you have any Tattoos or permanent make-up? _____yes _____ No

If yes what area(s) _____

Do you have a history of any of the following?

Yes

No

- | | | |
|-----|-----|--------------------------------------|
| ___ | ___ | Acne |
| ___ | ___ | Skin Cancer |
| ___ | ___ | Skin Disorder |
| ___ | ___ | Fever Blisters |
| ___ | ___ | Herpes Outbreaks |
| ___ | ___ | Difficulty Healing Wounds |
| ___ | ___ | Hepatitis |
| ___ | ___ | Diabetes |
| ___ | ___ | Glaucoma |
| ___ | ___ | Tested for HIV: When ___ / ___ / ___ |

Current

Medications: _____

Drug Allergies: _____

Current Medical Problems: _____

Additional Comments:

I have provided a full and truthful medical history and have listed all medications to this office.

Patients Signature

Date:

Pre Laser Evaluation Form (Fill out only if having a **Laser** procedure)

Do you currently use: Tanning Beds, Artificial Tanning cream or lotions? ___ Yes ___ No

When did you last tan your skin? _____

Have you ever had Laser hair removal before? ___ Yes ___ No

If yes what area(s) _____

What methods of hair removal do you currently use? _____

Have you ever had: Dermabrasion, Chemical Peels, Cosmetic surgery, Sclerotherapy (Vein removal)? ___ Yes ___ No

* If yes to any: When: ___/___/___

Please Specify Procedure(s):

Are you currently using Accutain, Retin-A, Renova, or any products containing an Alpha-Hydroxy Acid? ___ Yes ___ No ___ other

If yes, which products? _____

Please choose one of the following

Skin Type:

- ___ Always burns, never tans
- ___ Always burns, sometimes tans
- ___ Sometimes burns, always tans
- ___ Rarely burns, always tans
- ___ Black Skin

I agree that I have read and understand the above, and given full disclosure. I certify that if any changes occur in my medical history/ health regime, that I will notify this office prior to further treatments. I have authorized treatment by signing this form.

Signature

Date: