No	Yes	Do you take any prescription or over the counter medications? Please List:

No	Yes	Do you currently, or have you ever had any of the following conditions?	Resolved	Controlled	Uncontrolled
		Medication Allergies (specify)			
		Severe Food Allergies (specify)			
		Autoimmune Disorder (Lupus, RA, Psoriasis) or other (please list)			
		HIV or AIDS			
		☐ Hypertension ☐ Hypotension			
		Heart condition			
		Blood Clotting Condition			
		Diabetes ☐ Type 1 ☐ Type 2			
		Herpes Simplex - Cold Sores/Fever Blisters/ Genital			
		Staph Infection			
		Asthma			
		Lung Disorder			
		Hepatitis			
		Kidney Disease			
		Skin Cancer (specify type, location, and date)			
		Cancer (specify type and date)			
		Thyroid Disease- Hyper or Hypo?			
		Shingles (specify location and last episode)			
		Seizures			
		Wounds that stay brown after healing			
		Keloid Scarring (scars that grow beyond the border of the injury)			
		Slow Wound Healing			
		Sensitive Skin (specify)			
		Electrical implants (pacemaker, ect.)			
		Metal implants (not including dental fillings)			
		Previous complications with cosmetic lasers			
		WOMEN: Currently pregnant or breastfeeding			
		WOMEN: abnormal menstrual cycle			
		WOMEN: Trying to become pregnant			
		Tattoos/permanent makeup (specify)			
		ANY OTHER HEALTH CONDITIONS			

***The above health questionnaire is accurate. I agree to disclose all changes to my health at future visits.**

Print Name: _____ Signature: _____

Date of Birth: _____

LT/PA/NP/MD Signature: _____