

**Laser / Esthetic Medical History Form**

Name \_\_\_\_\_ Date \_\_\_\_\_

1. What is the purpose of your visit today? \_\_\_\_\_

2. What results do you wish to have? \_\_\_\_\_

3. Have you recently or are you currently having any other facial or complexion treatments?  
 yes  no

4. What type of facial products do you use? \_\_\_\_\_

5. Do you drink caffeine?  yes  no How much per day? \_\_\_\_\_

6. Do you drink water?  yes  no How much per day? \_\_\_\_\_

7. Do you use sunscreen daily?  yes  no What SPF? \_\_\_\_ Face only  All over

8. Do you wear contact lenses?  yes  no

9. Are you currently using tanning beds?  yes  no

If yes, have you tanned in the last 30 days?  yes  no

10. Do you use facial waxing or depilatories?  yes  no

If yes, when was your last treatment? \_\_\_\_\_

11. Do you have acne or an occasional breakout?  yes  no

12. Are you currently seeing a doctor for acne?  yes  no

13. Are you using acne or other topical facial medications?  yes  no

14. Are you currently using any medications?  yes  no

List all medications you are currently using: \_\_\_\_\_

\_\_\_\_\_

List any medication you have discontinued within the last 30 days: \_\_\_\_\_

\_\_\_\_\_

Are any of the above listed medications ones that make you sensitive to the sun: \_\_\_\_\_

15. Are you allergic to any medications?  yes  no

If yes, please list: \_\_\_\_\_



1. Are you using Retin-A or Renova?  yes  no

2. Do you have a history of allergies to cosmetics?  yes  no

List ingredients to which you are allergic: \_\_\_\_\_

3. Do you have a history of keloids or pigmented scarring?  yes  no

4. Do you have a history of seborrhea, rosacea or other facial rash?  yes  no

5. Have you had any laser, radiation, cryosurgery, electrosurgery, or injection treatments in the past six months?  yes  no

**“Yes” answers to any of the above questions may indicate the possibility of skin sensitivity/reaction**

1. Do you have an autoimmune disease (such as lupus)?  yes  no

2. Do you smoke?  yes  no

3. Do you drink alcohol?  yes  no

**“Yes” answers to any of the above questions may indicate slow healing**

1. Have you taken Accutane within the past six months?  yes  no
2. Do you currently have any warts on your face?  yes  no
3. Do you have epilepsy?  yes  no
4. Do you have a history of herpes simplex? (fever blisters/cold sores)  yes  no
5. Are you currently pregnant or breast feeding?  yes  no
6. Do you have HIV, or been exposed to it?  yes  no
7. Do you have Hepatitis, or been exposed to it?  yes  no
8. Do you have any tattoos in the areas you would like treated?  yes  no
9. Do you have any beauty marks that you want to keep in the areas that you want treated?  yes  no
10. Do you currently have a sunburn, or any cuts or abrasions in the areas to be treated?  yes  no
11. Circle one of the following statements as it relates to your skin:
  - I. Always burn, never tan
  - II. Always burn, sometimes tan
  - III. Sometimes burn, sometimes tan
  - IV. Rarely burn, tan with ease
  - V. Moderately pigmented, always tan
  - VI. Deeply pigmented, never burn

**“Yes” answers to any of the above questions may indicate certain procedures should not be done at this time.**

**\*The following should only be answered if you are a female interested in hair removal\***

Please check all that apply:

- yes  no Acne that is unresponsive to treatment
- yes  no Obesity
- yes  no Irregular or painful menses
- yes  no Family history of excess hair in female members of the family
- yes  no Hair loss/thinning of scalp hair

**\*Signature for all patients\***

**Patient's Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (Or legal guardian)

**Patient's Name:** \_\_\_\_\_

**Legal guardian's name:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date** \_\_\_\_\_