



HEALTH HISTORY

Today's Date: _____ Date of Birth (mm/dd/yyyy) _____ Age _____ Sex: F M

Last Name: _____ First: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip _____

Cell Phone _____ Home Phone _____

Please provide Email to receive monthly specials _____

Occupation: _____ WHERE DID YOU HEAR ABOUT US? (Please be specific): _____

SHOULD PRESCRIPTIONS BE PRESCRIBED, PLEASE LIST YOUR PHARMACY _____

PRIMARY CARE PHYSICIAN _____ **DERMATOLOGIST** _____

MEDICAL HEALTH HISTORY (Circle any condition for which you have ever been treated)

- | | | | |
|----------------------------|---------------------|----------------------------|--------------------|
| KELOID SCARRING | MRSA INFECTION | DEPRESSION | SMOKER |
| HERPES (OR COLD SORES) | SEIZURES | HIGH BLOOD PRESSURE | LUNG DISEASE |
| AUTOIMMUNE DISORDER | KIDNEY DISEASE | ARTHRITIS / GOUT | HEART DISEASE |
| BLOOD DISORDERS | EASY BRUISING | HORMONAL IMBALANCES | CURRENTLY PREGNANT |
| CANCER / RADIATION THERAPY | PACEMAKER | HX OF ACCUTANE USE | POOR HEALING |
| DIABETES | SKIN DISEASE/CANCER | POLYCYSTIC OVARY SYNDROME | BLOOD CLOTS |
| HEPATITIS/HIV | SKIN GRAFT | NUMBER OF PREGNACIES _____ | STEROID USE |

LIST ALL MEDICATION ALLERGIES (including allergy to eggs)

****PLEASE NOTIFY YOUR HEALTH CARE PROVIDER IF YOU HAVE AN ALLERGY TO LATEX:**

LIST ALL CURRENT OR PAST HEALTH CONDITIONS:

LIST ALL SURGERIES:

LIST ALL MEDICATIONS INCLUDING ASPIRIN AND HERBAL SUPPLEMENTS.

HAVE YOU HAD PREVIOUS LASER TREATMENTS, BOTOX, FILLERS, COSMETIC PROCEDURES? (LIST)

HAVE YOU EVER HAD ANY COMPLICATIONS DUE TO ANY OF THE ABOVE (INCLUDING, BUT NOT LIMITED TO, FACIALS, EXTRACTIONS, AND MICRODERMABRASION)