

**AESTHETIC LASER CENTER of SEATTLE**

509 OLIVE WAY SUITE 1133  
SEATTLE, WA 98101

**LASER MEDICAL HISTORY FORM**

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

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ DOB \_\_\_\_\_

e-mail \_\_\_\_\_ Day phone \_\_\_\_\_ Gender \_\_\_\_\_

Referred by \_\_\_\_\_ Name of Primary Care Physician \_\_\_\_\_

List area(s) to be treated \_\_\_\_\_

List any past laser treatments \_\_\_\_\_

Have you used any of the following hair removal methods in the past 4 weeks?

- Shaving       Waxing       Electrolysis       Sugaring       Tweezing       Depilatories

Are you currently under a dermatologist care? \_\_\_\_\_ If so why? \_\_\_\_\_

Are you currently under a physicians care? \_\_\_\_\_ If so why? \_\_\_\_\_

List any current or chronic medical illnesses \_\_\_\_\_

List any medications you are currently taking \_\_\_\_\_

- Retin-A/Renova/Differin       Accutane       Obagi       Antibiotics       St. John's Wart

List any allergies \_\_\_\_\_

Do you have any current or past skin conditions? \_\_\_\_\_

- Herpes (Cold Sores)     Skin Cancer     Blemishes     Psoriasis     Eczema If Checked, Location \_\_\_\_\_

Do you have any family history of skin conditions? \_\_\_\_\_

Are you interested in Chemical peels/Microdermabrasion/Microneedling/Skin Care Advise? \_\_\_\_\_

Are you using any topical skin medications/creams? \_\_\_\_\_

Are you pregnant?  Yes  No      Do you sunbathe?  Yes  No      Do you use sunscreen?  Yes  No

When did you last expose your body to the sun, tanning beds or tanning creams? \_\_\_\_\_

Skin Tone:     Freckled     White     Olive     Brown     Black    What is your ethnicity? \_\_\_\_\_

- Check one:     I    Always burns, never tans                       IV    Rarely burns, always tans  
                   II    Always burns, sometimes tans                     V    Brown, Moderately pigmented skin  
                   III    Sometimes burns, always tans                    VI    Black Skin