Medical History – Aesthetics *(Rev 23.03.01)*

MALISSE Skin Bar

Patient Name: _____ DOB: _____ Age: _____ Gender: _____

Please answer the questions below. This information will assist us in providing you with the best care possible.

Do you have an active infection, fever, flu, cold sores or cold symptoms?	Yes	No
Have you used medications or herbs that may cause photosensitivity (sensitivity to 515-1200 nm light exposure)? For example, Isotretinoin (Accutane), and tetracycline, St. John's Wort, Doxycycline or Tretinoin)	Yes	No
In the 3 or 4 weeks prior to treatment, were you exposed to the sun or used artificial tanning creams or sprays?	Yes	No
Are you planning an event or vacation in the next 3 to 4 weeks that will expose you to the sun?	Yes	No
Are you pregnant or lactating?	Yes	No
Do you wear contact lenses?	Yes	No
Do you have tattoos or permanent make-up?	Yes	No
Do you smoke?	Yes	No

Do you have a history of any of the following conditions?

Cancer	Yes	No	Erythematosus or Porphyria	Yes	No	Herpes Simplex/Cold Sores	Yes	No
Fear of needles	Yes	No	History of Fainting	Yes	No	Amyotrophic Lateral Sclerosis	Yes	No
Blood Disorder	Yes	No	Myasthenia Gravis	Yes	No	Clotting/Bleeding Disorder	Yes	No
Diabetes	Yes	No	Eaton Lambert Disorder	Yes	No	Multiple Sclerosis	Yes	No
Bells Palsy	Yes	No	Liver Disease/Hepatitis	Yes	No	HIV/AIDS	Yes	No
Anemia	Yes	No	Rosacea	Yes	No	Eczema	Yes	No
Acne	Yes	No	Skin Rash or Disease	Yes	No	Palpitations	Yes	No
Melasma	Yes	No	Keloids/Excessive Scarring	Yes	No	Very Dry Skin	Yes	No
Psoriasis	Yes	No	Frequent Severe Headaches	Yes	No	Polycystic Ovarian Syndrome	Yes	No
Seizures	Yes	No	Tobacco Use	Yes	No	Allergies or Sensitivities (Gluten, etc.)	Yes	No

1. If you answered Yes to any of the above, please provide a detailed explanation in the space below:

_____

2. Please list and explain other diseases or conditions you have had:

_____

3. Please list all medications, herbal supplements or over-the-counter medications you are taking.

_____

4. Do you have any Allergies or/Sensitivities? Yes No If Yes, please explain

_____

5. Have you ever been treated for a skin condition? Yes No If Yes, please explain

_____

Have you had previous cosmetic procedure(s)? If yes, please check the appropriate box(es).

❑ Facials/Chemical Peels ❑ Waxing ❑ Electrolysis ❑ BOTOX ❑ Dermal Fillers ❑ Photo Facial ❑ Laser Resurfacing ❑ Surgery

❑ Sclerotherapy ❑ Laser Hair Removal ❑ Microdermabrasion ❑ Depilatories/Hair Removal Creams (i.e. Nair) ❑ Laser Spider Vein

What Type? When? _____

Skin Type: ❑ Light Pale White ❑ White, Fair ❑ Medium, White to Olive ❑ Olive, Moderate Brown ❑ Brown, Dark brown ❑ Black

Patient Signature: _____ Date: _____