Dr. Laser Practitioner
The Best Laser Office
1234 Your Street
City, State 22222

Medical History
for Laser / BBL™ Skin Procedures

Sample

Name: ____

Address: ____

Phone #1: ______________________ **Phone #2:** ______________________

Female ☐ **Male** ☐ **Age:** __________ **Referred by:** ______________________

Reason for consultation

☐ Acne

☐ Brown spots or sun damage

☐ Enlarged blood vessels

☐ Fine lines or wrinkles

☐ Flushing of the skin

☐ Skin laxity

☐ Skin texture or scars

☐ Unwanted hair

Questions about skin

1. How long have you been concerned about this area(s)?

____

2. At what age did you notice this concern(s)?

____

3. Are your present skin concern(s) getting more pronounced? ☐ Yes ☐ No
4. Have you ever been treated for this concern(s)? ☐ Yes ☐ No

If yes, when? ____

What method? ____

5. Are you currently taking medication for your skin's concern(s)? ☐ Yes ☐ No

If yes, what is it? ____

6. What topical skin medications or products are you currently taking?

☐ Retin-A® ☐ Hydroquinone or bleaching agent ☐ Other ________________________________

7. Have you ever had laser / IPL hair removal? ☐ Yes ☐ No
8. Have you ever used the following hair removal methods in the past 6 weeks?

☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories

9. Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No
10. Have you ever had treatments for pigmented lesions? ☐ Yes ☐ No
11. Do you form thick or raised scars (keloids) from cut or burns? ☐ Yes ☐ No
12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? ☐ Yes ☐ No
13. Have you had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- Always burns, never tans ☐
- Always burns, sometimes tans ☐
- Sometimes burns, always tans ☐
- Rarely, burns, always tans ☐
- Brown, moderately pigmented skin ☐
- Black skin ☐

1. When were you last exposed to the sun or tanning booth?

____

2. Do you use self tanners? ☐ Yes ☐ No
3. Are you planning a vacation in the sun? ☐ Yes ☐ No

Sample

Personal history:

1. Do you smoke? ☐ Yes ☐ No if yes ______ packs per day
2. What is your daily consumption of alcohol?

____

3. Do you wear contact lenses? ☐ Yes ☐ No

Medical history:

1. Are you currently under the care of a physician? ☐ Yes ☐ No. If yes, for what:

____

2. Do you have any of the following?

☐ Arthritis
☐ Any active infection
☐ Bleeding disorders
☐ Bruising
☐ Dark spots of pregnancy
☐ Diabetes

☐ Epilepsy or seizures
☐ Heart disease
☐ Hepatitis
☐ Herpes simplex
☐ High blood pressure
☐ Hormone imbalance

☐ HIV / Aids	☐ Sensitive teeth	☐ Skin injury
☐ MRSA	☐ Skin cancer or moles	☐ Vision deficits
☐ Other________________		

3. Do you have allergies to any of the following? (check all that apply) ☐ medications ☐ latex

   ☐ food ☐ plants ☐ anesthesia ☐ other____

4. Do you take any of the following?

☐ Accutane
☐ Antibiotics
☐ Anti-coagulants
☐ Anti-depressants

☐ Appetite depressants
☐ Aspirin or Ibuprofen
☐ Cortisone or steroids
☐ Hormone/contraceptives

☐ Insulin ☐ Thyroid medication

☐ Sedatives ☐ Other____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) ☐ Yes ☐ No

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For female patients:

1. Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: ____ **Date:** ____________________