Medical History Form

Client Name: _____ Date of Birth: _____

Address: _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

General Information

1. Are you currently under the care of a Physician? (circle one) **Yes / No** If yes, complete:

    Name of Physician: _____

    Address: _____

    Phone: _____

    Condition(s): _____

2. Are you currently under the care of a Dermatologist? **Yes / No** If yes, complete:

    Name of Dermatologist: _____

    Address: _____

    Phone: _____

    Condition(s): _____

3. Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? **Yes / No**

4. Do you have any of the following medical conditions? (check all that apply)

    - Cancer
    - Frequent cold sores
    - Seizure disorder
    - Blood clotting abnormalities Any active infection
    - Arthritis
    - Diabetes HIV/AIDS Hepatitis
    - High blood pressure
    - Keloid scarring
    - Hormone imbalance
    - Herpes
    - Skin diseases
    - Lesions
    - Thyroid imbalance

5. Do you have any other health problems or medical conditions? **Yes / No** If yes, please list:

    _____

    _____

6. Have you ever had an allergic reaction to any of the following? **Yes / No** If yes, check all that apply:

    - Food _____
    - Latex
    - Aspirin
    - Hydrocortisone
    - Hydroquinone
    - Lidocaine
    - Others _____

Medications

7. Are you taking any oral/topical medications? **Yes / No** If yes, check all that apply:

    - Birth Control (name) _____
    - Hormones (type) _____
    - Others _____

8. Are you on any mood altering or anti-depression medication? **Yes / No** If yes, please list:

_____

9. Have you ever used Accutane? **Yes / No** If yes, last used: _____

10. Do you use herbal supplements regularly? **Yes / No** If yes, please list:

_____

History

11. Have you ever had laser hair removal? **Yes / No**

12. Have you had any recent tanning or sun exposure? **Yes / No**

13. Do you form thick or raised scars from cuts or burns? **Yes / No**

14. Do you have Hyperpigmentation (darkening of the skin), or Hypopigmentation (lightening of the skin or marks) after physical trauma? **Yes / No**

15. Have you ever had local anesthesia with lidocaine? **Yes / No**

Female Clients

16. Are you pregnant or trying to become pregnant? **Yes / No**

17. Are you breastfeeding? **Yes / No**

18. Are you using contraception? **Yes / No** If yes, please explain:

_____

Skin Type

Which of the following best describes your skin type? (circle one)

- **I.** Always burn, never tan
- **II.** Always burn, sometimes tan
- **III.** Sometimes burn, always tan
- **IV.** Rarely burn, always tan
- **V.** Brown, moderately pigmented skin
- **VI.** Heavily pigmented skin, very dark hair

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I HAVE PROVIDED A THOROUGH AND COMPLETE MEDICAL HISTORY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE.

_____

Patient Signature & Date

_____

Treatment Provider Signature & Date

_____

Medical Director Signature & Date