

LASER SERVICES
Personal Profile and Health History

What procedures are you interested in?

Please share any questions, concerns, or comments:

Are you pregnant? Y N Are you breastfeeding? Y N

Your genetic background affects your skin and its responses to laser treatments.
Please specify your ethnic origin:

African-American Asian Caucasian Hispanic Mediterranean

Middle Eastern Native American Other: _____

Please list ALL medications, including prescriptions and over the counter drugs,
vitamins, herbs, or supplements that you have taken in the last 12 months:

Are you allergic to any medications? Y N

If yes, please list medications and reactions:

Medical History: Please circle all that apply.

Acne	High blood pressure	Seizures
Bleeding Disorders	Hirsutism	Shingles
Burns/Skin Grafts	Hormone Replacement Med	Skin Cancer
Chemotherapy	Implants	Tattoos
Diabetes	Kaposi's Sarcoma	Thyroid Disease
Endocrine Disorders	Keloid Scars	Vitiligo
Gold Therapy	Lupus Erythematosus	Other
Heart Disease	Permanent Makeup	
Hepatitis	Precocious Puberty	
Herpes	Psoriasis	

Please list any surgery/surgical procedures you have had in any area being
considered for treatment:

If the answer to any of the following questions in yes, please provide details in the space provided.

- Are you currently being treated for any medical conditions? Y N
Explain: _____
- Have you used Accutane in the last 12 months? Y N
How recently? _____
- Do you have any active skin diseases or infections in the area to be treated? Y N
Explain: _____
- Do you have any skin allergies? Y N
Explain: _____
- Are you allergic to latex, lidocaine, or any lotions? Circle all that apply. Y N
- In the last 2 weeks, have you used glycolic acid, Retin A or alpha hydroxy acid? Y N
- Have you had a chemical peel or facial within the last week? Y N
- Have you had any permanent cosmetic tattooing to the area to be treated? Y N
- Do you have any metal or other implants? Y N
If yes, where? _____
- Have you had any previous laser treatment or other skin treatment to the area to be treated? Describe: _____ Y N
- Are there any moles with hair in the area to be treated? Y N
- Are you currently using or have you used within the last six weeks a tanning bed or tanning cream? If yes, date of last use: _____ Y N
- Have you been exposed to the sun within the last four to six weeks? Y N
If yes, approximate date of last exposure: _____
- Do you scar or bruise easily? Y N
- Do you heal quickly from a cut or abrasion on the skin? Y N
- Are you prone to cold sores or fever blisters? Y N
- Do you have a history of genital herpes? Y N
- Have you taken in the last 2 weeks any antibiotics or medications that warn against sun exposure? If yes, list medication: _____ Y N
- Are you or have you been on any blood thinners in the last 6 months (Heparin, Coumadin, Warfarin, Aspirin, etc)? Y N
- Is your skin tanned? Y N
- Do you use sunscreen daily? If yes, what SPF: _____ Y N
- Have you taken St. John's Wart in the last 2 weeks? Y N
- Have you waxed, tweezed, or used a chemical depilatory in the last 2 weeks? Y N

What products are you currently using on your skin?

What kind of results would you like to see from this treatment?

What is your motivation for wanting this treatment?
