Advanced Laser Medspa

PATIENT HISTORY QUESTIONNAIRE

Date: ____________________________

First Name: ______________________________ Last Name: _______________________________________

Date of Birth:_____________________

Address:____________________________________City:________________ State:_______ Zip:_________

Phone:______________________ home/work/cell Phone:____________________________ home/work/cell

Email Address: _______________________________

Employer: ________________________ Occupation:__________________ Work Phone:_______________

Emergency Contact: ________________________________ Emergency Contact Phone: _______________

Reason for Consultation: ____

Primary Care Physician: ____Phone: __________________

Currently under physicians care?_____________________

How did you hear about Advanced Laser Medspa?________________ If Referral, who?________________

Have you ever had any of the following conditions? Check all that apply.

___	Allergies	___	Fainting/Concussion	___	Melanoma
___	Anemia	___	Hay Fever	___	Nervous/Emotional Disorders
___	Arthritis	___	Heart Disease	___	Phlebitis
___	Asthma/Wheezing	___	Heart Murmur	___	Radiation Therapy
___	Bleeding Disorder	___	Hepatitis A, B, or C	___	Sexually Transmitted Disease
___	Blepharoplasty	___	High Blood Pressure/ Hypertension	___	Sinus Problems
___	Blood Transfusion/ Donating	___	Hyper pigmentation	___	Skin Cancer
___	Chemotherapy/ Radiation	___	Herpes Simplex	___	Stomach Problems
___	Circulatory Problems	___	Infection (active)	___	Stroke
___	Cold Sores	___	Immune Disorders	___	Thyroid Problems
___	Diabetes	___	Keloids	___	Tumors/Growths
___	Dizziness /Vertigo	___	Kidney Disorders	___	Tuberculosis Exposure

___ Eczema/Psoriasis ___ Liver Disorders ___ Ulcers

List all current medications/supplements that you are currently taking: ______________________________
____

List all past or recent surgeries:____
____

List any drug, make-up and skin allergies and hypersensitivity reactions: ____________________________
____

Do you have a latex allergy? _________yes ________No (I do NOT have a latex allergy)

Are you taking any oral or inject able steroids? __________ yes __________ no

If yes, please explain.____

Patient History Questionnaire

Have you ever /are currently using any of the following? If so, how long?

Retin-A	____	yes	____	no	Date: _______________
Renova	____	yes	____	no	Date: _______________
Any Retinoic Acid Product	____	yes	____	no	Date: _______________
Accutane	____	yes	____	no	Date: _______________
Prescription Acne Medication	____	yes	____	no	Date: _______________

Are you pregnant?___________ yes ____________no If yes, how far along? ______________________

Are you currently taking birth control pills or other forms of contraceptive?___________ yes __________ no

If yes, what?____

When was the date of your last period?____

Have you ever been tested for HIV?________ yes __________ no Results?___________________________

What is your natural hair color?_______________________ Eye color?____________________________

Have you recently undergone a skin peel? __________yes __________no If yes, how long ago?_________

Is your skin condition normal or abnormal?____

When did you last tan your skin?________________ Sun, tanning beds, creams?_________________

Have you ever had sclerotherapy? __________yes __________no If yes, how long ago?____________

When a scar appears on your skin, is it significantly dark in color? ____________yes ______________no

Fitzpatrick Skin Test

(Please circle the one that describes your skin type.)

Type I: Always burn, never tans. Red or blond hair, light eyes

Type II: Somewhat tans, mostly burns

Type III: Sometimes burns, mostly tans, also known as "olive" complexion

Type IV: Rarely burns, almost always tans, also known as "olive" complexion

Type V: Moderately pigmented (Indian, Hispanic, ect)

Type VI: African American

Skin Type: (circle one) Oily Normal Dry Sensitive Combination

Patient History Questionnaire
(Please check any previous cosmetic treatments.)

____ Acid Peel/ Microdermabrasion When?____

____ Laser treatments When?____

____ Injectables (Botox, Juvderm etc) When?____

____ Plastic Surgery When?____

____ Botox When?____

____ Waxing When?____

Please check any allergies to the following:

____ Soy ` Reaction:____

____ Milk Reaction:____

____ Eggs Reaction:____

____ Sugar/Beets Reaction:____

____ Retinoic Acid Reaction:____

____ Aspirin Reaction:____

____ Lidocaine Reaction:____

____ Epinephrine/ Adrenaline Reaction:____

____ Grapes Reaction:____

____ Apples Reaction:____

____ Tomatoes Reaction:____

____ Citric Fruits Reaction:____

Please describe any skin, body or hair issues that bother you: ______________________________

____

What are you hoping to improve with yourself here at Advanced Laser Medspa? _________________

____

Going back three generations, what is your family ancestry? (Ex: Swedish, Polish, German, etc.)______

____

Patient Print Name: ____________________ Patient Signature: ___________________________