Laser / Chemabrasion Intake history

Name _____ Date: _____

MR# _____

DOB: _____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

What medical problems do you have? (please check and explain below)
What surgeries have you had?

High Cholesterol	_____	Cancer	_____
Heart disease / Heart Attack	_____	Seizure / Epilepsy	_____
Stroke / mini-stroke	_____	Kidney disease	_____
high blood pressure	_____	Liver disease	_____
carotid artery disease	_____	Heart burn / GERD	_____
peripheral vascular disease	_____	Back pain	_____
blood clots / PE	_____	Arthritis	_____
aneurysm	_____	Vision problems	_____
Passing out	_____	Skin conditions	_____
Falls / Gait dysfunction	_____	Irritable Bowel	_____
Pneumonia	_____	Anxiety / Depression	_____
Asthma	_____	Diabetes	_____
COPD / emphysema	_____	Thyroid Disease	_____
Tuberculosis (TB)	_____	Anemia	_____
Stomach ulcers	_____	HIV	_____

Other? Please explain any above. List all surgeries with dates.

_____

_____

What problems do you have with your skin?

acne	_____	psoriasis	_____	scarring	_____
rash	_____	fine lines	_____	keloids	_____
rosacea	_____	wrinkles	_____	redness	_____
eczema	_____	loss of pigment	_____	roughness	_____
moles	_____	scleroderma	_____	skin cancer	_____

Do you wear foundation? _____
Do you use sunless tanning agents? _____
Do you tan (in the sun or a bed)? _____
Do you burn easily in the sun? _____

Which classifies your skin? Check one.

Always burn, never tan, very light skin _____
Usually burn, tan with difficulty _____
Sometimes mild burn, tan is average _____
Rarely burn, tan with ease. _____
Very rarely burn, tan very easily _____
No burn, tan very easily, very dark skin _____

List your medications in the form of the example. Include vitamens and herbals.

Drug	Dose/mg	Frequency
Snake oil	500mg	daily

Drug	Dose/mg	Frequency

What do you currently do to remove hair?

_____

_____

Have you had any laser treatments to your skin before? Yes No

Do you have varicose veins? Yes No

Do you have spider veins? Yes No

Do you have small, visible blood vessels on your face? Yes No

What area are you interested in having laser hair removal?

Face	_____	abdomen	_____
Upper lip	_____	back	_____
Chin/neck	_____	upper arms	_____
sideburns	_____	lower arms	_____
ears	_____	legs	_____
brow	_____	bikini area	_____
chest	_____	buttocks	_____
nipples	_____	other	_____
armpits	_____		

Do you have a history of herpes coldsores?	Yes	No	
Do you smoke?	Yes	No	**If yes, how much?**
Have you been told you are HIV positive?	Yes	No	_____
Do you have Diabetes?	Yes	No	
Have you ever been diagnosed with skin cancer?	Yes	No	

Have you had any radiation treatment to your skin?	Yes	No
Have you ever used Gold-based medications?	Yes	No
Have you ever used Accutane or any other retinol based medication?	Yes	No
Have you used any retinol skin applications?	Yes	No
Do you use glycolic/alpha-hydroxy/fruit acid based skin applications?	Yes	No
Have you had Botox or any fillers (collagen, Restylane, etc)?	Yes	No

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****Women only****

Are your menstraul periods regular?	Yes	No
Have you noticed an increase in weight over the years?	Yes	No
Have you noticed an increase in hair growth over the years?	Yes	No
Have you been told you have Polycystic Ovarian Syndrome (PCOS)?	Yes	No
Are you pregnant or do you plan on becoming pregnant in the next year?	Yes	No

Do you have anything special coming up---class reunion? Prom? Party?

_____

Doctor's signature upon review. **Patient's signature** **Date**

_____ _____

The above is true and correct to the best of my belief.