Client Name:_____

Medical History Form

GENERAL

Do you see your physician on a regular basis? O Yes O No If yes, please list DATE of last visit :_____

Are you currently under the care of a dermatologist? O Yes O No If yes, please note reason:_____

Do you have a history of persistent skin rash produced by prolonged or repeated sun exposure? O Yes O No

Do you have a history of cancer? O Yes O No If so, please list type:_____

Any cancer lesions removed in the areas to be treated O Yes O No If so, please list area and DATE:_____

Do you have any of the following conditions?

O Active infection	O Arthritis	O Blood Clotting	O Cold Sores
O Dermatitis	O Diabetes	O Eczema	O Epilepsy/Seizure
O Heart Disease	O Hepatitis	O Herpes	O High Blood Pressure
O HIV /AIDS	O Hormone Imbalance	O Hypertension	O Keloid Scarring
O Moles	O Metallic Implant	O Pace Maker	O Psoriasis
O Rosacea	O Skin Disease/Skin Lesions: _____		O Tattoos
O Thyroid Imbalance	O Vitiligo / Lupus	O Warts	

Do you have any other health problems or medical conditions? Please note: _____

_____

Are you pregnant or trying to become pregnant? O Yes O No **Are you breastfeeding?** O Yes O No

Are you using contraception? O Yes O No If so, please list: _____

Do you smoke? O Yes O No **Have you consumed 2 or more glasses of alcohol in the last 24 hrs?** O Yes O No

Have you ever had an allergic reaction to any of the following? (Describe the reaction you experienced)

O Food O Latex O Aspirin O Lidocaine O Hydrocortisone O Hydroquinone or skin bleaching agents O Aloe Vera O Metal

O Other: _____

MEDICATIONS

What oral medications are you presently taking? O Birth control pills O Hormones O Anticoagulants O Aspirin O Analgesics O Anti-inflammatory O Anti-epileptics O Antibiotics O Insulin O High blood pressure drugs O Others (please note):_____

Are you on any mood altering or anti-depression medication? O Yes O No

Have you ever used Accutane? O Yes O No. If yes, when did you last use it? _____

What topical medications or creams are you currently using? O Retinol A, O Retin-A, O Retinoids O Tazorac

O Others (please note): _____ **Doctor's note for prescription topical** Requested_____

What herbal supplements or vitamins especially vitamin A & C do you use? _____

HISTORY

Have you ever had light-based treatments? O Yes O No

Have you used any of the following hair removal methods in the past six weeks?

O Shaving O Waxing O Electrolysis O Plucking O Tweezing O Stringing O Depilatory Cream O Laser

Have you had any recent tanning or sun exposure that changed the color of your skin? O Yes O No

Is your usual work environment out-of-doors? O Yes O No

Have you recently used any self-tanning lotions or treatments from tanning beds? O Yes O No

Do you form thick or raised scars from cuts or burns? O Yes O No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? O Yes O No If yes, please describe: _____

Medical History Form -2-

Please Note: Ultimately, we are here to help you and want your experience to be a pleasant one. We thrive on providing a safe and effective treatment and wish to assist in any way possible; it is <u>your responsibility over the duration of your treatments</u> to tell us if there has been a change in medication, prescriptions; topical or otherwise, or a change in your health and if you have had others skin care treatments outside our office or a change in home skin care regime and/or product used. Skin reactions can occur though rare, and are avoidable if you follow our standard recommendations. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Please enter score number at the end of each row. HOW DOES YOUR SKIN RESPOND WITHOUT SPF?

	0	1	2	3	4	SCORE
EYE COLOUR	LIGHT OR BLUE	BLUE OR GREEN	HAZEL OR LIGHT BROWN	DARK BROWN	BROWNISH BLACK	
NATURAL HAIR COLOUR	RED, SANDY RED	BLONDE	DARK BLONDE, CHESTNUT BROWN	DARK BROWN	B LACK	
COLOUR OF SKIN (Buttocks Area, Stomach, inside arm)	REDDISH	VERY PALE	PALE WITH BEIGE TINT	LIGHT BROWN	DARK BROWN	
FRECKLES ON SUN EXPOSED AREAS	MANY	SEVERAL	FEW	ODD ONE OR TWO FRECKLES	NONE	
WHEN IN THE SUN TOO LONG MY SKIN IS	PAIN, REDNESS, BLISTERING, PEELING	BLISTERING FOLLOWED BY PEELING	BURNS SOMETIMES FOLLOWED BY PEELING	RARELY BURNS	NEVER HAD BURNS	
HOW BROWN DO YOU GET	HARDLY pANY OR NOT AT ALL	LIGHT TAN	REASONABLE TAN	TAN VERY EASILY	TURN DARK BROWN QUICKLY	
DO YOU TURN BROWN SEVERAL HOURS AFTER TANNING	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS	
WHAT HAPPENS TO YOUR FACE WHEN IN THE SUN	VERY SENSITIVE	SENSITIVE	NORMAL	CAN HANDLE SUN	NEVER HAD A PROBLEM	
WHEN IS THE LAST TIME YOU TANNED INCLUDING TANNING BEDS AND SELF TANNING LOTIONS	MORE THAN 3 MONTHS AGO	2-3 MONTHS AGO	1-2 MONTHS AGO	LESS THAN 1 MONTH AGO	LESS THAN 2 WEEKS AGO	
HOW OFTEN IS THE AREA TO BE TREATED EXPOSED TO SUN	NEVER	HARDLY EVER	SOMETIMES	OFTEN	ALWAYS	
ETHNIC BACKGROUND AND UV FITZPATRICK SCORE	0-7: I	8-16: II	17-25: III	26-30: IV	OVER 30: V-VI	

I confirm that I am not pregnant at this time, and that I have not applied topical Retinol A, Tazorac, Steroid creams or other prescription Retinoids within the last week, nor have I taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I understand that how I take care of my skin after treatment influences my risk of complications. I agree to follow the clinics recommendations**. I agree to stay out of the sun or tanning beds and to use sufficient sun <u>block</u> for 2 - 4 weeks following my treatment**. I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them.

I certify that the preceding medical, personal and skin history statements are true and correct.

Client Signature: _____ **Print Name:** _____ **Date:** _____

Service Provider / Witness: _____ **Date:** _____