

MEDICAL HISTORY

NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

AGE: _____ REFERRED BY: _____

Have you ever suffered from the following?

Diabetes	Yes	No
Bleeding Disorder	Yes	No
Autoimmune Disorder	Yes	No
Herpes	Yes	No

Are you pregnant Yes No

Do you wear contacts Yes No

Are you currently taking any of the following medications?

Steroids	Yes	No
Aspirin	Yes	No
Antibiotics	Yes	No
Accutane	Yes	No
Retin A	Yes	No
Herbal preparations	Yes	No

What is your daily consumption of alcohol? _____

Any allergies to medications? _____

List any medications you are currently taking: _____

PLEASE CIRCLE YOUR SKIN TYPE (WHEN EXPOSED TO THE SUN WITHOUT PROTECTION FOR ABOUT ONE HOUR)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, sometimes tans
- IV Always tans
- V Hispanic, Asian, Mediterranean, Middle Eastern
- VI Black

When were you last exposed to the sun (including tanning booths)? _____

Do you use chemical sun tanning lotions? Yes No

Are you planning a holiday in the sun? Yes No

Have you ever had skin resurfacing or photo rejuvenation before? Yes No

Have you ever had treatments for pigmented lesions? Yes No

Any personal or family history of melanoma? Yes No

Reason for visit (area/areas to be treated): _____

Any other relevant history? _____
