NORTH SIDE LASER

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address; _____

City: _____ State _____ Zip Code: _____

Telephone: Home: _____ Work _____ Cell: _____

Date of Birth: _____ Sex: Female Male

Family Doctor; _____ phone: _____

Pharmacy; _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body treatment would you like to complete?_____

Please answer all of the following questions

1. Do you have **ANY** current or chronic medical Illnesses?

   Disclose any history of heat uticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral Infections medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness,

   Please List: _____

   YES NO ☐ ☐

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehleis-Danlos syndrome, scleroderma, skin cancer, or other skin condition? Please list:

   _____

3. Are you currently under a doctor's care? if so, for what reason? ☐ ☐

   _____

4. Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: ☐ ☐

   _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please list: ☐ ☐

   _____

6. Do you take/use ANY systemic/oral steroids (e.g, prednisone, dexamethasone)? ☐ ☐

   _____

MEDICAL HISTORY, CONTINUED

		YES	NO
7.	Do you have **ANY** allergies to medications, foods, latex or other Substances? Please List; _____	☐	☐
	(For women) are you or could you be pregnant?		
8.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder or a menstrual dysfunction?	☐	☐
9.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
10.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
11.	Do you have a history of light induced seizures?	☐	☐
12.	Do you have any open sores or lesions?	☐	☐
13.	DO you have any history of radiation therapy in the area to be treated?	☐	☐
14.	In the last six (6) months, have you used any of the following; anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: In the last three (3) months, h~~ave y~~ou used any of the following products; glycolic acid, other alpha hydroxy, or beta hydroxy acid products? _____ Any exfoliating or resurfacing products or treatments? Please list product name and date last used: _____	☐	☐
15.	Do you have or have you ever had any permanent make-up, tattoos, implants, or dermal fillers, including, Out not limited to, collagen, autologous fat, Restylane, etc.? If yes, please list locations on or in the body and dates: _____	☐	☐
16.	Do you have or have you ever had any Botulinums, such as Botox or Dysporto? If yes, please list locations on or in the body and dates: _____ _____	☐	☐
	Have you taken Accutane (or products containing isotretinoin) in the last 12 months?		
17.	Have you taken Tretinoin (like Retin-A, Renova 49) in the last 6 months?	☐	☐
18.	Have you had any unprotected sun exposure, used tanning creams (Including sunless tanning lotions) or tanning beds or lamps In the last 4-6 weeks?	☐	☐
19.	Have you been diagnosed with diabetes?	☐	☐

Signature: _____ Date _____

NORTH SIDE LASER

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Signature: _____ Date _____