

## Clinical Information and Past Medical History

**Name:** ..... **Sure Name:** ..... **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Mailing Address:** .....  
**Email:** ..... **Mobile:** ..... **Home Phone:** .....  
**Family Doctor:** ..... **Emergency Contact Name and Number:** .....

**Please answer each of the following questions:**

1. Do you have **ANY allergies** to medications, foods, latex, or other substances? Please List:

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2. Do you smoke? YES / NO Average per day? \_\_\_\_\_

3. Do you consume alcohol? YES / NO Average per day? \_\_\_\_\_

4. Do you have ANY current or chronic following medical conditions? \_\_\_\_\_

	Yes	No		Yes	No
Autoimmune disorder or any immunosuppression			Diabetes		
Heat urticaria			Cancer		
Blood disorders			Bacterial or viral infections		
Skin photosensitivity disorders			HERPES (Cold sore)		
Keloid formation			Allergic dermatitis		
Vitiligo			Lichen planus		

6. Do you take ANY medications including vitamins C, E, Omega 3, pain killer, and herbal supplements like green tea on a regular basis? Please List:

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7. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? No  / Yes  Please List: \_\_\_\_\_

<b>AESTHETIC MEDICAL HISTORY FORM</b>	<b>YES</b>	<b>NO</b>
Are you taking oral steroids (e.g., prednisone, dexamethasone)?		
Do you have a pacemaker or external defibrillator?		
Do you have any metal implants under the area being treated?		
Do you have a history of light-induced seizures?		
Do you have a history of Herpes in the area being treated?		
Do you have any open sores or lesions?		
Have you had radiation therapy in the area being treated?		
Do you have a history of keloid scarring or hypertrophic scar formation?		
Have you taken Accutane or Tretinoin (eg. Retin-A, Renova) in the last 6 months?		
Have you had any unprotected sun exposure or tanning beds/lamps in the last month?		

In the last 6 months, have you used any Anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatories ? List Product, Date Used: \_\_\_\_\_

Have you had any cosmetic procedures in the past 6 months? Please Describe: \_\_\_\_\_

Have you had any permanent make-up, tattoos, implants, or fillers, including but not limited to collagen, fat, dermal fillers, etc.? If yes, please list locations and dates: \_\_\_\_\_

In the last 6 months, have you been treated with Botox or Dysport? YES / NO If yes, please list: \_\_\_\_\_

### **For Women Only:**

1. Are you pregnant or breastfeeding? YES / NO
2. Are your menstrual periods regular? YES / NO
3. Have you been diagnosed with Polycystic Ovarian Disorder? YES / NO

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_