

## PATIENT MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell # or Preferred Contact #: \_\_\_\_\_ Is it important to be discrete? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Describe the nature of your visit? \_\_\_\_\_

\_\_\_\_\_

What are your expectations? \_\_\_\_\_

\_\_\_\_\_

Please fill out any of the following that may apply:

### **Medical History:**

Heart Condition: \_\_\_\_\_ Keloids: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Cold Sores/Herpes: \_\_\_\_\_

Perm Makeup/Tattoos: \_\_\_\_\_ Pregnant or Lactating: \_\_\_\_\_

Have you been on Accutane in the past 6 months? \_\_\_\_\_

Include any other medications that make you photo sensitive: \_\_\_\_\_

Any Allergies: \_\_\_\_\_

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin etc.): \_\_\_\_\_

\_\_\_\_\_

**Any Allergies:** \_\_\_\_\_

### **Acne:**

Do you have a history of breakouts? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, what is the frequency of your breakouts? \_\_\_\_\_ Frequent \_\_\_\_\_ Occasional \_\_\_\_\_ Rarely

Do you experience cystic breakouts? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any scarring as a result from your acne? \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Skin Background:**

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, are you currently sunburned? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you use tanning beds? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you using chemical tanning solutions? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you use sunscreen on a regular base? \_\_\_\_\_ Yes \_\_\_\_\_ No

