

**patient consultation & medical history**

**Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**Address:** \_\_\_\_\_ **Birthday:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_ **E-Mail:** \_\_\_\_\_

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

Please check the items that concern you, and list their location:

Concerns:

Location:

- Pigmentation
- Lines/Wrinkles
- Bumps/papules
- Redness
- Rosacea
- Pores
- Skin Laxity
- Scars
- Veins/Capillaries
- Hair

Please describe any previous treatment you have had for these concerns:

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Did you have any problems with these treatments? Yes/No

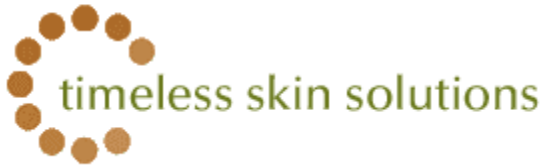
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Have you tanned or used self-tanning products in the past 2 weeks? Yes/No

Do you use sunscreen? Yes/No SPF: \_\_\_\_\_



Please circle yes or no to the following conditions:

|                           |        |                         |        |
|---------------------------|--------|-------------------------|--------|
| Neuromuscular problems:   | Yes/No | Keloids:                | Yes/No |
| Pregnant/lactating:       | Yes/No | Cold sores/herpes:      | Yes/No |
| Heart disease:            | Yes/No | Skin cancer:            | Yes/No |
| Permanent make-up/Tattoo: | Yes/No | Other (please specify): |        |
| Respiratory problems:     | Yes/No |                         |        |

Are you currently using Retinoids or Accutane? Yes/No \_\_\_\_\_

Are you using Vitamin E, Aspirin, or Coumadin? Yes/No \_\_\_\_\_

Please list all the medications (prescription & over-the-counter) you are currently taking:

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Do you have any medical allergies? Yes/No

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What is your heritage?

Caucasian       Hispanic       Asian       Mediterranean  
 African American     American Indian     Indian       Other (please specify):

What skin care products are you currently using?

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Do you smoke? Yes/No

**I certify that the above medical history information is accurate and correct.  
I am aware that the initial office visit with our medical staff is \$60.00 due  
at the time of consultation. This fee will be deducted from the first procedure.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr/Tech Signature: \_\_\_\_\_ Date: \_\_\_\_\_