TOTAL
SKIN & BEAUTY DERMATOLOGY CENTER

Medical History: Aesthetic Laser Patients

Name:_____ DOB:_____

Address:_____

Home Phone:_____ Business Phone:_____

Age:_____ Referred by:_____

Have you ever suffered from the following?

Diabetes ❒ Yes ❒ No
Blood disorder ❒ Yes ❒ No
Are you pregnant? ❒ Yes ❒ No

What medications are you taking (including aspirin)? _____

_____

What is your daily consumption of alcohol? _____

Allergies: _____

_____

Are you taking any herbal preparations (St. John's Wort, etc.)? ❒ Yes ❒ No

If yes, please list:_____

Do you wear contact lenses? ❒ Yes ❒ No

Mark your skin type (when exposed to the sun **without protection** for about 1 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	African American/Black	❒

When were you last exposed to the sun (including tanning booth/bed)?_____

Do you use chemical sun tanning lotions? ❒ Yes ❒ No

Are you planning a holiday in the sun? ❒ Yes ❒ No

Reason for visit (area to be treated):_____

Have you ever had skin resurfacing or photorejuvenation before? ❒ Yes ❒ No

Have you ever had treatments for pigmented lesions? ❒ Yes ❒ No

Prior treatment (if any):_____