Date:_____

Name:_____ AGE:_____ * DOB:_____
Last First

ADDRESS:_____ CITY:_____ ZIP:_____

HOME PHONE:_____ ☐ OK TO CONTACT/LEAVE MESSAGE HERE

MOBILE PHONE:_____ ☐ OK TO CONTACT/LEAVE MESSAGE HERE

WORK PHONE:_____ ☐ OK TO CONTACT/LEAVE MESSAGE HERE

E-MAIL:_____ ☐ OK TO CONTACT/LEAVE MESSAGE HERE

OCCUPATION:_____ REFERRED BY:_____

Please list in order of importance, beginning with 1, what you would like to improve about your skin:
_____ Reduction of fine lines _____ Reduction of oil/acne _____ Reduction of redness _____ Reduction of brown spots/sun damage
_____ Reduction of hair _____ Acne scars diminished _____ Tattoo_____ Other *For minors, please list guardian info.

Medical history	Yes	No
Are you or is it possible that you may be pregnant?		
Are you breastfeeding?		
Do you form thick or raised scars from cuts or burns?		
After injury to the skin (such as cuts/burns) do you have: (circle) Darkening of the skin in that area (hyperpigmentation) Lightening of the skin in that area (hypopigmentation)		
Hair removal by plucking, waxing, or electrolysis in the last 4 weeks?		
Tanning (tanning bed) or sun exposure in the last 4 weeks? (circle)		
Tanning products or spray on tan in the last 2 weeks?		
Do you have a tan now in the area to be treated?		
Do you use sunscreen daily with spf 30 or higher?		
History of skin cancer or unusual moles?		
Have you ever had a photosensitive disorder? (E.g. lupus)		
History of seizures?		
Permanent make-up or tattoos? Where _____		
Have you used Accutane in last 6 months?		
Are you currently taking antibiotics? Which _____		
Are you using Retin-A or Glycolic products? (circle)		
Are you currently under the care of a physician?		
Do you currently smoke?		
Do you have an allergy or sensitivity to lidocaine, latex, sulfa medications, hydroquinone, aloe, and bee stings? (circle)		
Life threatening allergy to anything?		
Do you have scars on the face?		

Explanation of items marked "Yes":

_____

_____

Please check all medical conditions past or present	Yes	No
Keloid scarring	☐	☐
Cold sores	☐	☐
Herpes (genital)	☐	☐
Easy bruising or bleeding	☐	☐
Active skin infection	☐	☐
Moles that changed, itched, or bled	☐	☐
Recent increase in amount of hair	☐	☐
Asthma	☐	☐
Seasonal allergies/allergic rhinitis	☐	☐
Eczema	☐	☐
Thyroid imbalance	☐	☐
Poor healing	☐	☐
Diabetes	☐	☐
Heart condition	☐	☐
High blood pressure	☐	☐
Pacemaker	☐	☐
Disease of nerves or muscles (e.g. ALS, myasthenia gravis, Lambert-Eaton or other)	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐
Autoimmune disease (e.g. rheumatoid arthritis, scleroderma)	☐	☐
Hepatitis	☐	☐
Shingles	☐	☐
Migraine headaches	☐	☐
Other illness, health problems, or medical conditions not listed.	☐	☐

Explanation of items marked "Yes":

_____

_____

I certify that the medical information I have given is complete and accurate. Signature: _____ _____ Initials

For Internal Use Only Below This Line

_____

_____

_____