MEDICAL HISTORY

NAME: ____

ADDRESS: ____

HOME PHONE: ___________________BUSINESS PHONE: __________________

AGE: ___________   REFERRED BY: ____________________________________

Have you ever suffered from the following?

Diabetes	Yes	No
Bleeding Disorder	Yes	No
Autoimmune Disorder	Yes	No
Herpes	Yes	No

Are you pregnant	Yes	No
Do you wear contacts	Yes	No

Are you currently taking any of the following medications?

Steroids	Yes	No
Aspirin	Yes	No
Antibiotics	Yes	No
Accutane	Yes	No
Retin A	Yes	No
Herbal preparations	Yes	No

What is your daily consumption of alcohol? ___________________________________

Any allergies to medications? ____

List any medications you are currently taking: ________________________________

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PLEASE CIRCLE YOUR SKIN TYPE (WHEN EXPOSED TO THE SUN WITHOUT PROTECTION FOR ABOUT ONE 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	Black

When were you last exposed to the sun (including tanning booths)? ________________

Do you use chemical sun tanning lotions?	Yes	No
Are you planning a holiday in the sun?	Yes	No
Have you ever had skin resurfacing or photo rejuvenation before?	Yes	No
Have you ever had treatments for pigmented lesions?	Yes	No
Any personal or family history of melanoma?	Yes	No

Reason for visit (area/areas to be treated): ____________________________________

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Any other relevant history? ____

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