



**NEW PATIENT PERSONAL INFORMATION**

*Please complete the following:* Date: \_\_\_\_\_

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

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

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

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

How were you referred? \_\_\_\_\_

Please list all allergies (including medications, food, poultry, latex, cosmetics, lidocaine, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications, including herbal (esp. St John's Wort) or over the counter, you take on a regular basis, or have taken in the last six months:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all operations (including plastic/laser procedures), hospitalizations, and any serious illnesses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your concerns (please circle any of the following):

Unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, other (please list): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have a history of:

	Yes	No	Dates
Insulin dependent Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Cancer	___	___	_____
Blood Clots	___	___	_____
Stroke	___	___	_____
Serious Cardiac Disease	___	___	_____
Bleeding problems with cuts, surgery	___	___	_____

Jaundice or Hepatitis	___	___	_____
Thyroid Disease	___	___	_____
Active Skin Disease/Lesions	___	___	_____
Dizziness, palpitations, fainting spells	___	___	_____
Cold Sores, mouth blisters, fever blisters	___	___	_____
Weight change of 10lbs in last 6mo.	___	___	_____
Psychiatric Disorders	___	___	_____
Arthritis	___	___	_____
Seizure Disorder	___	___	_____
Hormone Imbalance	___	___	_____
Herpes	___	___	_____
HIV/Aids	___	___	_____
Keloids/Scars	___	___	_____
Active Infection	___	___	_____
Vitilgo, scleroderma, lupus, hives	___	___	_____
Tattoos or Permanent Makeup	___	___	_____
Other	___	___	_____

Please Elaborate on any yes answers \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Which of the following best describes your skin type? (please circle one skin type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin (Hispanic)
- VI Black skin

Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes No

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? Yes No

Have you ever used Accutane? Yes No  
 If yes, when did you last use it? \_\_\_\_\_

What topical medications or creams are you currently using? RetinA [ ] others (please list):

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks? shaving [ ]  
waxing [ ] electrolysis [ ] plucking [ ] tweezing [ ] stringing [ ] depilatories [ ]

Have you had any recent tanning or sun exposure that changed

the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes please describe: \_\_\_\_\_

Notify your physician (circle drug) if you have used any of the of the following in the last year (as they are a contraindication to some laser procedures): St. John's wort, accutane, tetracycline.

Circle any of the following medications you have taken in the last 6 months (as they may increase hair growth):

Birth control pills, androgens (rogaïne), penicillin, cyclosporins, minoxidil, steroids, haldol, phenytoin, thyroid medications.

For our Female clients: Are you pregnant or trying to become pregnant? Yes No

Are you using contraception? Yes No

Are you breastfeeding? Yes No

Have you ever smoked? Yes No How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you still smoking? Yes No When did you quit? \_\_\_\_\_

Are you currently under the care of a physician? Yes No

Are you currently under the care of a dermatologist? Yes No

Personal physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

*I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures. If you were referred by a physician, a letter will be sent to them outlining your treatment plan for their patient records, unless you notify us otherwise.*

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

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_