Patient Medical History

Today's Date: _____ Date of Birth: ____/____/_____ Age: _____ Sex: M / F

Name: _____

(First) (Middle) (Last)

Home Address: _____

Home Phone: _____ Work Phone:_____ Occupation: _____

GP: _____ GPAddress: _____

Emergency Contact:_____ Relationship: _____ Phone Number: _____

Please answer these questions and then complete the questionnaire on the back of this form

Have you ever been treated here before: NO YES

If yes, for what reason(s)? _____

Do you have any serious health conditions: NO YES

Have you suffered from epileptic fits? NO YES

Do you have any allergies? NO YES

If yes, please list _____

When you go into the sun without a tan, do you:

❑ Always burn, then tan ❑ Usually burn, sometimes tan ❑ Sometimes burn, usually tan ❑ Never burn, always tan

Do you have sensitive skin? NO YES

Have you ever had a skin problem or been under the care of a dermatologist? If yes, please describe (include dates under care):

Do you have any implants, tattoos or permanent makeup in / on the area to be treated NO YES Location?

Have you ever had X-ray treatment or radiation therapy to your skin? NO YES If yes, date diagnosed / treated:

Have you ever had Photodynamic Therapy (PDT)? NO YES If yes, date diagnosed / treated:

Present Medications Do you take any medications, drugs, or over the counter preparations / remedies?
(e.g. Roaccutane, Isotretinoin or other retinoids, St John's Wort, Amiodarone, Minocycline, Minocin, Dianette or other contraceptive pill, any steroids, Warfarin or other blood thinners, any iron supplements)
(Please list <u>any</u> medications or herbal remedies and where possible, date started, how many milligrams, how many times a day)

Have you ever used or had Renova or Retin A, Alpha hydroxyl, Glycolic Acid or other cosmetic peels? NO YES

Have you ever had Botox or fillers? NO YES

Prior hospitalizations and surgery in the last 5 years (Please give approximate dates)

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To help give the best possible care, please carefully complete all questions on this form. If unaware of an answer, leave it blank. Please circle "YES" or "NO." If yes, please include date diagnosed or treated.

Have you ever been treated for any of the following?		**Dates**
duodenal or peptic ulcer	NO YES	_____
other intestinal disease or colitis	NO YES	_____
liver disease or gall bladder disease	NO YES	_____
lung disease (tuberculosis, pleurisy, other)	NO YES	_____
heart disease (rheumatic fever, pacemaker, other)	NO YES	_____
high blood pressure	NO YES	_____
stroke	NO YES	_____
kidney disease	NO YES	_____
urinary or bladder problem/infection	NO YES	_____
venereal disease	NO YES	_____
blood disorder or lymph gland disorder	NO YES	_____
eye disease (glaucoma, cataract)	NO YES	_____
arthritis, joint problem, or bone disease	NO YES	_____
thrombophlebitis	NO YES	_____
cancer	NO YES	_____
frequent infections (skin or other)	NO YES	_____
neurological disorder	NO YES	_____
emotional or psychiatric problem	NO YES	_____
polycystic ovary syndrome (PCOS)	NO YES	_____

Have you ever been treated for one of the following?	**Dates**
eczema	NO YES_____
diabetes	NO YES_____
psoriasis	NO YES_____
skin cancer	NO YES_____
photosensitive reactions (e.g. lupus)	NO YES_____
excessive bleeding when cut	NO YES_____
overgrown scars/keloids	NO YES_____
allergy to local anesthetics	NO YES_____
Have you ever had a blood transfusion?	NO YES_____
Are you HIV positive?	NO YES_____
Do you have AIDS?	NO YES_____
Do you have cold sores?	NO YES_____
Have you taken Roaccutane or Accutane® in the last 6 months?	_____
Have you had gold therapy treatments?	NO YES

Women Only

Have you had vaginal yeast infections?	NO YES_____
Are you pregnant?	NO YES_____
Are you currently planning a pregnancy	NO YES_____

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

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Fitzpatrick Skin Type: 1 2 3 4 5 6 Skin Tan? _____ Hair Colour: _____

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