LASER TREATMENT PRE-QUALIFICATIONS & MEDICAL HISTORY FORM

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: Home: _____ Work: _____ Cell: _____
Date of Birth: _____ Gender: Female _____ Male _____ Other: _____
Family Doctor: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

How did you hear about our Laser services? Facebook ☐ Instagram ☐ Email ☐
I am an existing patient ☐ Other: _____

Which body area/areas or condition would you like treated? _____
_____
_____

What other Laser services are you interested in? Laser Hair Removal ☐ Skin Rejuvenation ☐
Sun Spots/Age spots ☐ Scar Reduction ☐ Wrinkle Reduction ☐ Pore Reduction ☐
Stretch Mark Removal ☐ Other: _____

What do you like about your skin? _____

If you could change something about your skin, what would it be? _____
_____

Please answer all of the following questions	**YES**	**NO**
1. Do you have **ANY** current or chronic medical illnesses? *Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.* Please List: _____ _____	☐	☐
2. Do you have **ANY** current or chronic skin conditions? *Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.* Please List: _____ _____	☐	☐

MEDICAL HISTORY, CONTINUED **YES** **NO**

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

_____

4. Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? ☐ ☐
   Please List:

_____

_____

5. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST)? ☐ ☐
6. Do you have **ANY** allergies to medications, foods, latex or other substances? ☐ ☐
   Please List:

_____

7. Do you take/use **ANY** systemic/oral steroids (e.g., prednisone, dexamethasone)? ☐ ☐
8. Do you have **ANY** allergies to medications, foods, latex or other substances? ☐ ☐
   Please List:

_____

9. (For women) are you or could you be pregnant? ☐ ☐
10. (For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder? ☐ ☐
11. Do you have a history of herpes I or II in the area to be treated? ☐ ☐
12. Do you have a history of keloid scarring or hypertrophic scar formation? ☐ ☐
13. Do you have a history of light induced seizures? ☐ ☐
14. Do you have any open sores or lesions? ☐ ☐
15. Do you have any history of radiation therapy in the area to be treated? ☐ ☐
16. In the last six (6) months, have you used any of the following anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: ☐ ☐

_____

_____

17. In the last three (3) months, have you used any of the following products: glycolic acid or otheralphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? ☐ ☐
    Please list product name and date last used:

_____

_____

18. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? ☐ ☐
    If yes, please list locations on or in the body and dates: _____

_____

19. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? ☐ ☐
    If yes, please list locations on or in the body and dates: _____

_____

20. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? ☐ ☐
21. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? ☐ ☐

MEDICAL HISTORY, CONTINUED **YES** **NO**

22. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? ☐ ☐
23. Are you willing to follow post-treatment care instructions? ☐ ☐

Patient Signature: _____Date: _____

For Provider Use Only:

Patient meets pre-treatment criteria and is eligible for scheduling. ☐ ☐

Provider Signature: _____Date: _____