All Care Laser Center

Medical History Form

Name: ____ **Date:** ______________

Birth Date: ____________ **Age:** ______ **Male:** _____ **Female:** _____ **Phone: H**____________________**W**_________________**C**________________

Address:____

How did you hear about our practice? ______________________________ **Email:**_________________

Have you had in the past or do you currently have:

Pigmentation issues, hyper or hypo pigmentation	Y	N	Heart Disease	Y	N
Diabetes	Y	N	Irregular Pulse	Y	N
Gold Therapy	Y	N	Fainting Spells	Y	N
Seizure Disorder (Epilepsy)	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Keloid Formation	Y	N
Polycystic Ovarian Syndrome	Y	N	Rosacea	Y	N
Irregular Menses	Y	N	Lupus	Y	N
Thyroid Disorder	Y	N	Hepatitis	Y	N
History of Herpes Simplex infections/fever blisters	Y	N	Chemotherapy	Y	N
Acne	Y	N	Skin Cancer	Y	N
Are you Photosensitive?	Y	N	Have you ever used **Retin-A**?	Y	N
Have you ever had a chemical peel or microderm?	Y	N	Have you ever taken **Accutane**?	Y	N
Do you have any Tattoos or permanent makeup?	Y	N	Cancer	Y	N
Have you ever had any laser treatments?	Y	N	Other medical issues or illnesses	Y	N

Medications: (Please list any medications you are currently taking including herbal supplements and vitamins)

____

What topical medications or creams are you currently using? Retin-A , Others?

____

Are you taking mood altering or anti-depression medication? Y N

Are you under the care of a physician? Y N If yes, why? ___________________________________

Drug Allergies: (Please list any known drug allergies):____

Have you had any recent tanning, sun exposure or used tanning creams that changed the color of your skin? ___YES ____NO

Do you use sunscreen? _____ What SPF? _____ Do you scar easily? _____ Do you heal quickly? _____

Have you used any of the following hair removal methods in the past six weeks?

Shaving ___Waxing __Electrolysis ___ Tweezing ___Threading ___ Depilatories ___

Please mark area(s) of interest:

Hair removal____	Brown spots____	Wrinkles____	Cellulite___	Botox____
Rosacea____	Facial/leg veins____	Sagging skin____	Inch loss___	Juvederm____

What treatments would you like to discuss today? ____

For our female patients:

Are you pregnant or trying to become pregnant? _____Yes ____No

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 staff at All Care Laser Center of my current medical or health conditions and to update this history with any changes that may occur. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____________________________________ Date: _________________