Aesthetic Medical History

Patient Name: ______________________________ Date: ______________

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: ______________________________	☐	☐
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.	Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: ______________________________	☐	☐
6.	(For women) are you or could you be pregnant?	☐	☐
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.	Have you ever taken oral or injected gold therapy?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	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: ______________________________	☐	☐
16.	Have you had surgery or other treatments; medical or cosmetic in the areas to be treated today? If yes, please list ______________________________	☐	☐
17.	Do you have or have you ever had a hernia?	☐	☐
18.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
19.	Do you have a history of fainting or passing out?	☐	☐
20.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
21.	Do you consider yourself claustrophobic or have issues with confinement?	☐	☐
22.	Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐