PATIENT PROFILE & HEALTH HISTORY FORM

Information contained here will be treated in a confidential manner and not released without your authorization. Please take the time to answer all appropriate questions to the best of your knowledge, as this information is important to us in decisions regarding your care.

Date:________________ Name:__________________________________ Date of Birth:____________ Age:___________________

Height:______________ Weight:_________________ Ideal Weight:____________ Sex:____________ Marital Status:___________

SS#:________________________Referred By:______________________________ Personal Physician:_______________________

Home Address:____

City:________________________________ State:__________ Zip:_____________ E-mail: _____________________________

Home Telephone:_____________________ Cell Telephone:___________________ Work Phone:___________________________

Occupation:__________________________________ Employer:____

Employer's Address:____

Please list all names of medications taken during the past 6 months: ____

____

Please list any allergies or sensitivities:____

____

Please list all previous operations, dates and any complications:____

Please list any health problems:____

Family health problems:____

Date/Result of last mammogram:_________________ Date of last menstrual period:________________ Are you pregnant?________

Do you smoke?:_______________ Avg # of packs per day:____________ # of years:______ Date quit:______________________

Do you drink beer or alcohol?:___________ How much?:_____________ How many caffinated beverages per day?:_____________

How much water?:_____________ Do you follow a special/restricted diet?:____

Please list any vitamins?:________________________ Topical medications (Retin-A, Accutane, etc.)?:_____________________

Please list any concerns you have about your skin:____

Do you experience breakouts, dryness, flakiness, redness?:____

Are you currently sun-tanned?:___ Sun exposure history:____

History of hair removal methods?:____

Please circle any of the following that may require pre-medication for laser treatment: hyperpigmentation skin ulceration yeast infections basal cell carcinoma bacterial infections herpes fungal infections

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Please let us know of any other concerns you may have that will make your visit with us an enjoyable one:______________________

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Signature:___________________________________