ALLURE SKIN & LASER

PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ Date of Birth ___/___/___ Birth Sex M / F Race(s) _____ Today's Date: ___/___/___

Email _____ Height: _____ Weight: _____

Phone Numbers *Provide your contact number(s) and check the box below for your preferred contact number.*

☐ Mobile _____ ☐ Home _____ ☐ Work _____

May we leave a detailed message? ☐ Yes ☐ No

Home Address _____ City _____ State _____ Zip Code _____

Emergency Contact (Last, First) _____ Phone _____

Pharmacy Name _____ Pharmacy Address _____ Phone _____

MEDICAL HISTORY

Select past and present medical conditions you have experienced:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation *(Irregular Heartbeat)*
- ☐ *Bone Marrow Transplantation*
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease/Cardiac Condition
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV / AIDS
- ☐ Hirsutism
- ☐ Hypertension *(High Blood Pressure)*
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Seizures
- ☐ PCOS
- ☐ Shingles
- ☐ Stroke

Cancers Other Than Skin: *Include type/location and treatment(s)* _____

Additional Medical Conditions: _____

PAST SURGERIES

☐ None **OR** **List all past surgeries:** _____

SKIN DISEASE HISTORY

☐ None If you have had any of the following skin conditions, provide details below *(including treatment dates and location(s))*:

SKIN CANCERS

- ☐ Basal Cell Carcinoma _____
- ☐ Melanoma _____
- ☐ Precancerous Moles _____
- ☐ Squamous Cell Carcinoma _____

☐ Additional skin conditions, infections or allergies: _____

SKIN CONDITIONS

- ☐ Acne _____
- ☐ Cold Sores/Fever Blisters _____
- ☐ Dry Skin _____
- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Rosacea _____
- ☐ Vitiligo _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ **Tanning salon usage?** ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

MEDICATIONS

List all medication names and dosages including over the counter, herbal supplements, prescription creams & skin care products.

☐ **No current medications** *(Examples: Retin-A, Renova, Differin, Tazorac, glycolic/AHA products)*

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ALLERGIES

List all allergies and reaction(s), including medication, food, and environmental.

☐ **No known allergies**

SOCIAL HISTORY

TOBACCO USAGE

☐ Never ☐ Former ☐ Current If a smoker, number of packs per day: _____ Total years smoking: _____ Tobacco Type: _____

ALCOHOL USAGE

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

Number of Days_____ ☐ None ☐ Decline to Specify

OCCUPATION: _____

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the past week:

☐ **None** ☐ Fever/chills ☐ Rash ☐ Joint pain

ALERTS

Select all that apply:

☐ **None**
☐ Allergy to lidocaine
☐ Bleeding Disorder
☐ Blood Thinners
☐ Breastfeeding
☐ Diastatis Recti
☐ Eating Disorder
☐ History of hernia or hernia repair
☐ History of tanning bed usage
☐ Hormone Replacement Therapy
☐ Hyperhidrosis
☐ Hyperpigmentation *(Skin Darkening)*
☐ Hypopigmentation *(Skin lightening)*
☐ Immunosuppression
☐ Irregular Periods
☐ Isotretinoin *(Accutane)*
☐ Kidney disease
☐ Latex allergy
☐ Liver disease
☐ Lupus
☐ Menopausal *(1st 12 months)*
☐ Metal or other implants
☐ Organ transplant
☐ Pacemaker/Electric Device
☐ Pregnancy or planning pregnancy
☐ Problems healing
☐ Problems scarring *(hypertrophic or keloid)*
☐ Radiation/Chemotherapy
☐ Rapid Heartbeat/Sensitivity to Epinephrine
☐ Tattoos
☐ Thyroid problems

ADDITIONAL QUESTIONS

How did you hear about us? _____

Have you had any previous laser, skin, Botox or filler treatments? _____

Which of the following concerns do you have about your skin/body?

☐ Acne
☐ Age Spots
☐ Aged Skin
☐ Cellulite
☐ Dry Skin
☐ Enlarged pores
☐ Hair Removal
☐ Leg Veins
☐ Melasma
☐ Oily Skin
☐ Pigment Changes
☐ Redness
☐ Rosacea
☐ Scars
☐ Sensitive Skin
☐ Skin Laxity
☐ Skin Texture
☐ Spider Veins
☐ Stubborn or pinchable fat
☐ Sun Damage
☐ Sweat/Odor
☐ Uneven Skin Color
☐ Whiteheads
☐ Wrinkles
☐ Other:

Which of the following services would you like to learn more about?

☐ Acne treatment
☐ Age spot treatment
☐ Botox
☐ Fat reduction
☐ Filler Injections
☐ Laser Hair Removal
☐ Laser Skin Rejuvenation
☐ Laser Vein Treatment
☐ Melasma
☐ MiraDry sweat & odor reduction
☐ Pigment Treatment
☐ Redness/Vessels
☐ Rosacea Treatment
☐ Scar Treatment
☐ Skin Resurfacing
☐ Skin Tightening
☐ Sun Damage Repair
☐ Wrinkle Treatment
☐ Other:

Photographic Consent:

I give consent to be photographed for the purpose of medical records ☐ Yes ☐ No

I give consent to be anonymously photographed for marketing and/or publication ☐ Yes