DermaHealth Laser Associates Medical History Questionnaire

Patient Name:_____ DOB:_____

Medications you are currently taking/using, including herbs, vitamins, and over the counter medication.
Oral:_____
_____
Topical:_____
Allergies: _____
What is the primary reason for your visit today?
_____

Have you had or do you currently have: (please check all that apply)

___ Skin Cancer
Type:_____
Location:_____
___ Lung problems
___ Asthma
___ History of cold sores
___ Blood disorder
___ Anemia
___ Hepatitis (type)_____
___ Polycystic ovaries

___Glaucoma
___ Heart valve replacement
___ History of Keloids
___ Kidney disease
___ Neurological disorder
___ Low blood sugar
___ Thyroid disease
___ High blood pressure
___ Diabetes
___ Rosacea
___ Acne

___ Joint disease
___ Immune System problems
___ History of cancer(type)____
___ History of stroke
___ Sinus problems
___ Arthritis
___ Pacemaker/Defibrillator
___ History of Accutane use
___ Ulcers/Gastrointestinal disease

Skin care history:

___ Waxing
___ Botox/Dermal fillers
___ Chemical peels
___ Implants
___ Fraxel

___ Permanent makeup/Tattoos
___ Sclerotherapy
___ Microdermabrasion
___ Previous laser treatments
___ Intense pulse light(IPL)/Photofacial

___ Retinoid use
___ Electrolysis
___ Laser veins
___ Gold therapy
___ Titan

Other: _____

Have you had any surgical procedures including cosmetic surgery? ___ Yes ___ No
If so, please describe:_____

Is there any family history of: (if yes, please describe family relation)

___ Yes ___ No Basal cell carcinoma relation_____
___ Yes ___ No Squamous cell carcinoma relation_____
___ Yes ___ No Melanoma relation_____
___ Yes ___ No Vitiligo relation_____
___ Yes ___ No Psoriasis relation_____
___ Yes ___ No Other skin disease relation_____

Female patient: (please check)

___ Contemplating pregnancy ___ Breastfeeding ___ Acne
___ Pregnant ___ Irregular Menses ___ Facial hair

All patients:

Do you smoke tobacco? If so, how much: _____
Do you drink alcoholic beverages? If so, how much:_____
Do you have a history of blistering sunburns or excessive sun exposure? _____
Do you have a history of tanning bed use? When and how often? _____
Is there any other condition concerning your health that the doctor should be told? If so, please describe. _____
Skin products past and present: _____
_____
Treatment goals:_____
_____

Areas you would like to discuss or receive more information (please check all that apply):

___ Freckles/brown spots
___ Dark circles
___ Sun damage
___ Large pores
___ Microdermabrasion
___ Wrinkles
___ Acne
___ Acne scarring
___ Laser hair removal
___ Laser treatments
___ Removing facial blood vessels
___ Leg spider veins
___ Excessive hair growth
___ Excessive sweating
___ Frown Lines
___ Chemical/antioxidant peels
___ Botox
___ Dermal fillers (Juvederm, Voluma)
___ Mouth(perioral) lines
___ Lower face folds
___ Lip augmentation
___ Facial redness
___ Rosacea
___ Skin care advice
___ Skin care products
___ Permanent makeup

___ Other, please specify:_____

Signature :_____ Date: _____
Print Name:_____