

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Telephone (home): _____ (mobile): _____ (work): _____

Date of Birth: _____ Gender: _____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

Please answer all the following questions:

YES NO

1. Do you have **ANY** current or chronic medical illnesses? YES NO

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? YES NO

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: _____

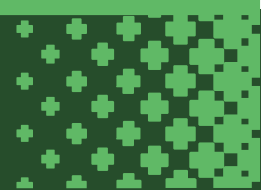
3. Are you currently under a doctor's care? If so, for what reason: YES NO

4. Do you take/use **ANY** medications (prescriptions and non-prescription), vitamins, herbal, or natural supplements, on a regular or daily basis? YES NO

Please list: _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular basis? YES NO

Please list: _____



- | | YES | NO |
|---|--------------------------|--------------------------|
| 6. Do you take/use ANY systemic/oral steroids (eg. Prednisone, dexamethasone)? Please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have ANY allergies to medications, foods, latex or other substances: Please list: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you receiving or have you received gold therapy? (rheumatoid arthritis) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. (for women) are you or could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. (for women) have you ever been diagnosed with Polycystic Ovarian Disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a history of Keloid scarring or Hypertrophic scar formation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a history of light induced Seizures ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you suffer from any recurrent skin infections including cold sores? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have ANY history of radiation therapy in the area to be treated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. In the last six (6) months, have you used ANY of the following: <ul style="list-style-type: none"> ♦ Anticoagulants or blood-thinning medications. ♦ Photosensitising medications; ♦ Anti-inflammatory medications Please list product name and date last used: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. In the last three (3) months, have you used ANY of the following products: <ul style="list-style-type: none"> ♦ Glycolic acid or salicylic acid; ♦ Alpha hydroxy or beta hydroxy acid products Please list product name and date last used: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. In the last three (3) months, have you used ANY exfoliating or resurfacing products or treatments? Please list product name and date last used: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have or have you ever had ANY permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane, etc? If yes, please list locations on or in the body and dates: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 19. Do you have or have you ever had ANY Botulinums, such as Botox or Dysport? If yes, please list locations on or in the body and dates: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you taken Accutane (or products containing isotretinoin) in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you taken Tretinoin (like Retin-A, Renova) in the last six (6) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

Client Signature: _____ Date: _____

Evaluator Signature: _____ Date: _____

