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? 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 or 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-prescription), 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 basis? Please list: _____ _____	☐	☐

	YES	NO
6. Do you take/use **ANY** systemic/oral steroids (eg. Prednisone, dexamethasone)? Please list: _____	☐	☐
7. Do you have **ANY** allergies to medications, foods, latex or other substances: Please list: _____ _____	☐	☐
8. Are you receiving or have you received gold therapy? (rheumatoid arthritis)	☐	☐
9. (for women) are you or could you be pregnant?	☐	☐
10. (for women) have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
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 suffer from any recurrent skin infections including cold sores?	☐	☐
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. • Photosensitising medications; • Anti-inflammatory medications Please list product name and date last used: _____ _____	☐	☐
16. In the last three (3) months, have you used **ANY** of the following products: • Glycolic acid or salicylic acid; • Alpha hydroxy or beta hydroxy acid products Please list product name and date last used: _____ _____	☐	☐
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: _____ _____	☐	☐
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: _____ _____	☐	☐

	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:_____ _____	☐	☐
20. Have you taken Accutane (or products containing isotretinoin) in the last 12 months?	☐	☐
21. Have you taken Tretinoin (like Retin-A, Renova) in the last six (6) months?	☐	☐
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?	☐	☐

Client Signature: _____ Date: _____

Evaluator Signature: _____ Date: _____