

Guest Information and Medical History

In order to provide you with most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

Personal History

Guest Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zipcode _____

Home Phone _____ Work Phone _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one type number)

1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black skin

Medical History

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Are you currently under the care of a dermatologist? Yes No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Do you have any of the following medical conditions? (Please circle all that apply)

Cancer	Diabetes	High Blood Pressure
Herpes	Arthritis	Frequent Cold Sores
HIV/AIDS	Keloid Scarring	Skin Disease/Skin Lesions
Seizure Disorder	Hepatitis	Hormone Imbalance
Thyroid Imbalance	Blood Clotting Abnormalities	Any Active Infection

Do you have any other health problems or medical conditions? Please list: _____
