FLAWLESS IMAGE MEDICAL AESTHETICS, LLC

5805 Bridge Street, East Syracuse, NY 13057 • (315) 694-6243

PATIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Patient Name_____Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address _____

City_____ State _____ Zip _____

Home/Mobile Phone (_____)_____Work Phone (____) _____

Email Address: _____

Emergency Contact Name and Phone _____

How did you hear about us? _____

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

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

Do you regularly use tanning salons or sun bathe?_____How often?_____

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 check 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: _____

_____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ❑Food ❑Latex ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others**:** _____

_____

MEDICATIONS

What oral medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (Please list): _____

Are you on any mood altering or anti-depression medication?_____

Have you ever used Accutane? ❑Yes ❑No, If yes, when did you last use it?_____

What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list):

_____

What herbal supplements do you use regularly?_____

Are you currently taking any blood thinners? ❑Yes ❑No

HISTORY

Have you ever had laser hair removal? ❑Yes ❑No

Have you used any of the following hair removal methods in the past **six weeks**?

❑Shaving ❑Waxing ❑Electrolysis ❑Plucking/Tweezing ❑Threading ❑Creams/Lotions

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑Yes ❑No

Have you recently used any self-tanning lotions or treatments? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑Yes ❑No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No If yes, please describe: _____

_____

For our female patients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No

Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature:_____ Date:_____

Printed Name: _____