MD IMAGES

Client 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.

PLEASE PRINT CLEARLY as it is important this information is read correctly by the laser center staff.

TODAY'S DATE: _____

PERSONAL HISTORY

Client Name: _____

Date of Birth:_____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Email Address: _____

Emergency Contact Info:

Name: _____ Phone: _____

How were you referred to MD Images? _____

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

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 erthema 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? ☐ Yes ☐ No

If yes, 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

Medical History - continued -

☐ Others allergic reactions

List Others and describe the reaction:

_____

_____

MEDICATION

What oral medications are you presently taking? ☐ Birth Control Pills ☐ Hormones

☐ Others List:

_____

_____

Are you on any mood altering or anti-depression medication? ☐ Yes ☐ No

If yes, please list:

_____

_____

Have you ever used Accutane? ☐ Yes ☐ No

If yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐ RetinA ☐ Other

Please list:

_____

_____

What herbal supplements do you use regularly?

_____

_____

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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 ☐ Stringing ☐ Depilatories

Have you had a recent tanning or sun exposure that changed your skin color? ☐ Yes ☐ No

Have you recently used 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 CLIENTS

Are you pregnant to trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you using contraception? ☐ Yes ☐ No

I certify that preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform MD Images and Sandra Richardson, Esthetician & Technician 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.

Client Signature: _____ Date:_____