Lakewood Ranch
Hair
Removal
Center

Patient Medical History

Name: _____ Date of Birth: _____

Address: _____

City _____ State _____ Zip: _____

Email: _____ Today's Date: _____

Home Phone:_____ Business Phone: _____

Cell # or Preferred Contact #: _____ Is it important to be discrete?_____

How did you hear about us? _____

Describe the nature of your visit? _____

_____

What are your expectations? _____

_____

Please fill out any of the following that may apply:

- ☐ Heart Condition
- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorders
- ☐ Hemophilia
- ☐ Frequent Infections
- ☐ Hepatitis Type____
- ☐ History of Histamine Reaction
- ☐ Hormone Imbalance
- ☐ Perm Makeup/Tattoos
- ☐ Polycystic Syndrome
- ☐ Sexual/Menstration Dysfunction
- ☐ Kelolds
- ☐ Cold Sores/Herpes
- ☐ Depression
- ☐ Bleeding Disorders
- ☐ Active Infections
- ☐ HIV/AIDS
- ☐ Oral Steroids
- ☐ Thyroid Imbalance
- ☐ Pregnant or Lactating
- ☐ Venereal Disease

Have you been on Accutane in the past 6 months?_____

Include any other medications that make you photo sensitive (antibiotics): _____

Have you taken ☐ doxycycline, ☐ minocin, ☐ minocycline, or ☐ vibramycin recently? When?_____

_____

List all medications you are currently taking (blood thinners, herbs, supplements, vitamins, aspirin etc.): _____

_____

Have you ever had allergic reactions to: ☐ Food ☐ Latex ☐ Nickel ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone

☐ Hydroquinone/Bleaching Agents ☐ Other_____

Are you currently under the care of a physician? If so, what for? _____

_____

Any Allergies: _____

_____

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Acne:

Do you have a history of breakouts? ☐ Yes ☐ No

If so, what is the frequency of your breakouts? ☐ Frequent ☐ Occasional ☐ Rarely

Do you experience cystic breakouts? ☐ Yes ☐ No

Do you have any scarring as a result from your acne? ☐ Yes ☐ No

Skin Background:

☐ Skin Disease: _____ ☐ Lesions: _____

☐ Chronic Rash: _____ ☐ Melanoma: _____

☐ Surgical Scars: _____ ☐ Psoriasis: _____

☐ Hairy Moles: _____

Are you currently under the care of a dermatologist? If so, for what? _____

Have you had prolonged sun exposure (or tanning bed) in the past 3 days? ☐ Yes ☐ No

If so, are you currently sunburned? ☐ Yes ☐ No

Do you use tanning beds? ☐ Yes ☐ No

Are you using chemical tanning solutions? ☐ Yes ☐ No

Do you use sunscreen on a regular basis? ☐ Yes ☐ No

Have you ☐ waxed, ☐ used depilatories, ☐ bleaches or other chemical processes? _____

How much water do you normally consume daily? _____

Do you exercise?	☐ Yes	☐ No	Do you have rosacea?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No	Do you have wrinkle concerns?	☐ Yes	☐ No
Do you drink alcohol?,	☐ Yes	☐ No	Do you have scarring concerns?	☐ Yes	☐ No
Are you caffeine free?	☐ Yes	☐ No	Do you have sun damage concerns?	☐ Yes	☐ No
Have you had microdermabrasion?	☐ Yes	☐ No	Do you have pigmentation concerns?	☐ Yes	☐ No
Have you had any chemical peels?	☐ Yes	☐ No	Do you have broken capillary concerns?	☐ Yes	☐ No
Have you had laser resurfacing?	☐ Yes	☐ No			

Have you had Botox or Collagen injections in the past 6 months? ☐ Yes ☐ No

If yes, and less then 3 months, approximate dates and location. _____

Do you use topical ointments? ☐ Retin-A ☐ Glycolic ☐ Lactic Acid ☐ Hydroquinone ☐ Other: _____

What type of skin care products are you using? _____

_____

Check other services of interest:

☐ Laser Hair Removal (list different areas) _____

☐ Laser Vein Removal ☐ Non-ablative LaserFACIAL ☐ Pigmented Lesions or Brown Spot Removal ☐ Other: _____

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____

DR/Tech Signature: _____ Date: _____