AH Laser Aesthetics

Personal Profile and Health History

Name: ______________________________ Cell Phone: ______________________

Address: ____ Date of Birth: ______________

Street

____ Age: __________

City State Zip

Email address: ____

Gender: ○ Male ○ Female ○ Transgender Female to Male ○ Transgender Male to Female ○ Prefer not to say
○ Non-Binary/Gender Queer/Gender Fluid ○ Prefer to self identify: ______________________

Preferred Pronouns: ○ She/Her ○ He/Him ○ They/Them ○ ______________________________

○ I am OK with receiving texts to confirm appointments at no extra charge.
○ I am OK with receiving emails to confirm appointments and communicate.
○ I am OK with my before and after photos being used for training and marketing purposes.

Occupation: ______________________________ Alternate phone #: ______________________

How did you hear about us? ○Google ○ IG/FB ○ Friend Friend's name: ______________________

What treatments are you interested in? ○ Botox ○ Fillers ○ Chemical Peels ○ Laser Hair Removal ○ Facials
○ Anti-Aging Treatments ○ Acne Treatments ○ Body Contouring ○ Laser Skin Treatments
○ Microneedling ○ Skin Care ○ Other ______________________________

Females: Are you pregnant? ○ Yes ○ No Are you breastfeeding? ○ Yes ○ No

Your genetic background affects your skin and its response to treatments. Please specify your ethnic origin:
○ African American ○ Asian ○ Caucasian ○ Hispanic ○ Mediterranean ○ Middle Eastern
○ Native American ○ Other ______________________________

Please complete the following items of medical history. Please, always inform us of any changes in your medical history and/or medications.

Please list **all** medications, including prescriptions and over the counter drugs, vitamins, herbs and supplements.

____

____

Are you allergic to any medications? ○ Yes ○ No If yes, please list the medications and your reactions.

____

Medical History: Please check all that apply.

○ Acne
○ Autoimmune disorders
○ Bleeding disorders
○ Burns/skin grafts
○ Diabetes
○ Herpes
○ Implants
○ Keloid scars
○ Lupus erythematosus
○ Permanent makeup
○ Polycystic ovary disease
○ Psoriasis
○ Seizures
○ Skin cancer
○ Tattoos
○ Vitiligo
○ Other ______________

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If the answer to any of the following questions is yes. Please provide details in the space provided.

1. Are you currently being treated for any medical conditions? ○ Yes ○ No

Explain: ______________________________

2. Have you ever used Accutane? ○ Yes ○ No How recently? ______________________________

3. Do you have any active skin diseases or infections in the areas to be treated? ○ Yes ○ No

4. Do you have any skin allergies? ○ Yes ○ No

Explain: ______________________________

5. Are you allergic to latex, lidocaine, or any lotions? ○ Yes ○ No

6. Are you currently using glycolic acid or Retin A? ○ Yes ○ No

7. Have you had a chemical peel or facial within the last week? ○ Yes ○ No

8. What products are you currently using on your skin? Products: ______________________________

9. Do you have any metal or other implants? ○ Yes ○ No Where? ______________________________

10. Have you had any previous laser treatment or other skin treatment to the area to be treated? ○ Yes ○ No

Describe: ______________________________

11. Any history of skin cancer? ○ Yes ○ No If yes, explain: ______________________________

12. Are you currently using or have you used within the last six weeks, a tanning bed or tanning cream?
○ Yes ○ No If yes, date of last use: _____ / _____ / _____

13. Do you wear sunscreen? ○ Yes ○ No

Name of your Primary care Physician (PCP): ______________________________

PCP Hospital Affiliation: ______________________________

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: ______________________________ Date: ______________

Signature of Consultant: ______________________________ Date: ______________

Clinician Review: ______________________________ Date: ______________

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