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: _____

For Office Use Only:	☐ eblasts	☐ Podium	☐ consents	☐ HIPAA	CC on file Y N	Amb cr _____ N/A