Skin Care & Laser Center

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Please arrive 10-15 minutes before your scheduled appointment.

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone_____ Other Phone_____

E-mail _____ To be used for clinical communication (appointment & care reminders, medical information & test results) and practice communication (announcements, newsletters, specials & events). We will never share or sell your email address. At any point, you may unsubscribe or opt-out of one or both types of communication.

Preferred Method of Contact (How should we contact you?): _____

Any restrictions for contacting you? □ No □ Yes Contact Restrictions_____

Birthdate____/_____/_____ Age_____ Gender_____

If Patient is a Minor:

Parent's Name_____ Birthdate_____
Home Phone _____ Cell Phone_____ Other Phone_____

Emergency Contact_____ Relationship to Patient_____
Home Phone _____ Work Phone_____ Cell Phone_____
Address_____
Street & Apt # City State Zip

❶	**Please help us by providing the reason(s) for your visit.**

❷	**Past Medical History**		
	Do you have or have you ever had any of the conditions or diseases listed below?	**YES**	**If YES, Please Briefly Describe.**
	Heart Problems		
	Phlebitis		
	Bleed Easily		
	Artificial Heart Valves/Joints		
	Fainting, Convulsions, Epilepsy, or Seizures		
	Cancer		
	Diabetes		
	HSV		
	Thyroid Disease		
	Kidney Disease		
	Hepatitis		
	Glaucoma		
	Organ Transplant		
	HIV or AIDS		
	Auto-Immune System Problems such as lupus, connective tissue disease, or RA		
	Reaction to Local Anesthesia/Lidocaine/Epinephrine		
	Sensitivity to Cold		
	Do You Have Any Other Serious Medical Conditions? Please Describe.		

❸	SKIN CARE PRODUCTS YOU CURRENTLY USE – Please List	
	Cleanser	
	Antioxidant	
	Sunscreen	
	Scrubs/Peels	
	Other	

❹	SERIOUS Hospitalizations and Surgeries – Medical and Dental	YES	NO
	Have you had any SERIOUS hospitalizations or surgeries?		

If YES, Please List Them with Dates

❺	SKIN HISTORY	YES	If YES, Please Describe
	Have you ever had melanoma? (Please Describe)		
	Have you ever had another type of skin cancer? (Please Describe)		
	Has anyone in your family ever had skin cancer? (Please Describe)		
	Have you ever had atypical nevi or moles?		
	Do you have any changing moles or spots?		
	Have you ever had any lesions that haven't healed?		
	Have you used Isotretinoin (Accutane) in the last year?		
	Do you have a history of any specific skin diseases or conditions?		
	Do you tan in a tanning bed or sunbathe?		
	Date of last Total Body Skin Exam?		
	Do you have a history of acne, eczema, or psoriasis?		

❻	Medications	YES	NO
	Are You Currently Taking Any Medications Including Aspirin, Pain Relievers, Herbals, Vitamins or Supplements?		
	If YES, Please List All Medications That You are Taking		
	Medications Dose		
	1		
	2		
	3		
	4		
	5		

❼	ALLERGIES	YES	NO
	Do you currently have any allergies?		
	If YES, Please List and Describe Reactions (i.e. seasonal, latex, anesthesia, medications, etc.)		

❽	Tobacco Use	YES	NO
	Do you smoke or have you ever smoked?		
	Do you or have you ever used chewing tobacco or snuff?		

Information Verification

By signing this form, I confirm that all information provided above is accurate and complete to the best of my knowledge

_____ _____

Signature Date