DERMALASE MEDICAL SPA

Patient Information and Medical History

Personal Information

Last Name	First Name	Middle Initial
Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Email Address		

Date of Birth	Sex	Age	Occupation
How were you referred to us?			

Emergency Contact Information

Primary Physician	Physician Phone Number
Primary Contact Name & Relationship	Primary Contact Phone Numbers
Secondary Contact Name & Relationship	Secondary Contact Phone Numbers

Medical History I

Please check if you have had any of the following:

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Herpes
- ☐ Menopause
- ☐ Sensitive to Anesthetic
- ☐ Lupus
- ☐ Glaucoma (or Family History)
- ☐ Irregular Menses Heart
- ☐ Hysterectomy Problems
- ☐ Hypertension
- ☐ Photosensitive Disorder
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Other

Medical History II

Please check and explain if you have had any of the following:

- ☐ Keloid Scars
- ☐ Hives
- ☐ Skin Cancer
- ☐ Waxing
- ☐ Electrolysis
- ☐ Cold Sores
- ☐ Hypersensitivity to Skin Products
- ☐ Skin Infections
- ☐ Tanning Within the Last 6 Weeks
- ☐ Use of Acne Products/Drugs
- ☐ Chemical Peels
- ☐ Photo Sensitizing Substances
- ☐ Laser Treatment of Any Type
- ☐ Eye Pressure Problems / Elevated Intraocular Pressure

Yes ☐ No ☐ Are you under the care of a physician?

Yes ☐ No ☐ Are you pregnant?

Yes ☐ No ☐ Do you have any current or recent medical illness or conditions not listed above?

Medications

Please list all current and recent medications / vitamins / eye drops etc.

- _____
- _____
- _____
- _____
- _____
- _____
-

Medication Allergies

Please list all medication allergies and reactions

☐ I have no medication allergies

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Aesthetic Treatment Types and Areas of Interest

Please check all aesthetic treatment types and associated areas of interest

☐	Sublative Wrinkle Reduction	Areas
☐	Spider Vein Treatment	Areas
☐	Intense Pulsed Light (IPL) Photo Rejuvenation	Areas
☐	Permanent Hair Reduction	Areas
☐	Sublime Skin Contouring	Areas
☐	Botox Injections	Areas
☐	Injectable Dermal Fillers	Areas
☐	VI Peels	Areas
☐	Chemical Peels	Areas
☐	Dermal Pen Micro Needling	Areas
☐	Facials	Areas
☐	Microdermabrasion	Areas
☐	Other	Areas

Prior Aesthetic Treatment Types and Areas

Please check all prior aesthetic treatment types and associated areas

☐	Sublative Wrinkle Reduction	Areas
☐	Spider Vein Treatment	Areas
☐	Intense Pulsed Light (IPL) Photo Rejuvenation	Areas
☐	Permanent Hair Reduction	Areas
☐	Sublime Skin Contouring	Areas
☐	Botox Injections	Areas
☐	Injectable Dermal Fillers	Areas
☐	VI Peels	Areas
☐	Chemical Peels	Areas
☐	Dermal Pen Micro Needling	Areas
☐	Facials	Areas
☐	Microdermabrasion	Areas
☐	Other	Areas

Skin Type

Please check the skin type that best describes your skin

☐	I	Burns easily; never tans; extremely sun sensitive	White	Red/blonde individuals w/ light complexion
☐	II	Burns easily; tans minimally; very sun sensitive	White	The largest % of Caucasian individuals are II or III
☐	III	Burns sometimes; tans gradually; some sun sensitivity	White/Asian	The largest % of Caucasian individuals are II or III
☐	IV	Burns minimally; tans easily; minimal sun sensitivity	Moderate Brown	Oriental, American Indian, Italian, Greek, Latin descent
☐	V	Burns rarely; tans well; no sun sensitivity	Dark Brown	Light complexion African-American or Indian descent
☐	VI	Never Burns; deep pigment; no sun sensitivity	Black	Dark skinned

Check Eye Color

☐ Blue	☐ Gray	☐ Green	☐ Hazel	☐ Brown	☐ Black

Check Current Natural Hair Color

(without dyes or rinses)

☐ Blonde	☐ Red	☐ Lt. Brown	☐ M. Brown	☐ Dk. Brown	☐ Black	☐ Salt & Pepper	☐ Gray

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Printed Name	Date of Birth
Patient Signature	Date

I understand that photographs will be taken before, during, and after my procedure(s) as a routine part of my care. I authorize DermaLase Medical Spa, or a representative, to take photographs or slides. I authorize the use of these images for research, educational informational purposes, publications in a medical journal and /or textbook, general advertising, publicity, or promotional purposes.

Patient Signature	Date