MAGNOLIA
DERMATOLOGY

MEDICAL HISTORY FORM (Laser/IPL) Date:_____

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone: Home: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Emergency Contact: _____ Phone: _____

What treatment/(s) are you interested in? Please circle: Improvement in red/brown spots, scars, stretch marks, texture, tone, hair removal, fine lines and wrinkles

What body area? _____

Please answer all of the following questions:

1. Do you have ANY current or chronic medical illnesses? Please disclose any history of heat urticaria, diabetes, autoimmune disorders (such as lupus) or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness. Please List:

_____

_____

2. Do you have ANY current or chronic skin conditions? Also disclose any history of vitiligo, eczema, lupus, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition. Please List:

_____

_____

3. Are you currently under a doctor's care? If so, for what reason? _____

_____

4. Do you take/use ANY medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: _____

_____

5. Are there any topical products (both prescription and non-prescription) that you use on your skin on a regular or daily basis? Please List:

_____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?

_____

7. Do you have ANY allergies to medications, foods, latex or other substances? Please List: _____

_____

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8. (For women) Are you or could you be pregnant/breastfeeding?

_____

9. (For women) Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Syndrome?

_____

10. Do you have a history of herpes or cold sores in the area to be treated?

_____

11. Do you have a history of keloid scarring or hypertrophic scar formation? _____
12. Do you have a history of light induced seizures? _____
13. Do you have any open sores or lesions?

_____

14. Do you have any history of radiation therapy in the area to be treated?

_____

15. In the last 2-4 weeks, have you used any of the following: anticoagulants or blood-thinning medications, photosensitizing medications or anti-inflammatory medications? Please list medications and the date last used:

_____

_____

16. In the last month, have you used any of the following products: glycolic acid or any acid products; exfoliating, resurfacing products, chemical peels or treatments? Please list product name and date last used:

_____

17. Do you have or have you ever had any permanent make-up, tattoos, implants, fillers, including, but not limited to Juvederm®, Voluma®, Restylane®, Radiesse®, Perlane®, Bellafill®, Artefill®, Sculptra®, collagen, etc.? If yes, please list areas treated and dates:

_____

18. Do you currently have or have you ever had any botulinum toxins such as Botox®, Xeomin® or Dysport®? If yes, please list areas treated and dates:

_____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 6 months?

_____

20. Have you used any retinoids/retinols (like Retin-A®, Tazorac ®, Tretinoin, Renova®) in the last month?

_____

21. Have you had any sun exposure, used tanning creams (including, sunless tanning lotions) or tanning beds in the last 4 weeks? _____

Signature: _____Date: _____Date of Birth:_____