

Weniger Plastic Surgery

Laser Medical History

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____
Email Address _____ DOB _____
Emergency Contact _____ Relationship _____
How did you hear about us today? _____

What type of problem are you consulting for:

- Resurfacing
- Hair Removal
- Sun spots
- Wrinkles
- Enlarged blood vessels
- Flushing of the skin
- Large pores

How many years have you noticed this problem? _____

At what age did your skin problem begin? _____

Are your present skin problems getting more pronounced? Yes No

Have you ever been treated for this problem? Yes No

If yes, when? _____

By what method? _____

Are you currently taking medication for your skin problem? Yes No

If yes, which medication? _____

Are you pregnant, nursing, or planning a pregnancy soon? Yes No

Do you have a history of bad scarring or discolored scars? Yes No

Do you have a history of:

- Heart disease Diabetes
- Cold sores/ fever blisters Bleeding disorders
- Bruising Dark spots after pregnancy
- Skin injury(red/brown) Skin cancer, or suspicious moles

Have you had any allergic reactions to topical anesthesia? Yes No

Do you have any skin related allergies? Yes No

If yes, please specify _____

Do you have any allergies to medication? Yes No

If yes, please specify _____

Do you take any medication?

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Anti-coagulants (blood thinners) |
| <input type="checkbox"/> Hormones/contraceptives | <input type="checkbox"/> Aleve, Advil, BC powder, Goody's |
| <input type="checkbox"/> Narcotic Pain medicine | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Sedatives | |
| <input type="checkbox"/> Prednisone or other topical steroids | <input type="checkbox"/> Other NSAIDS _____
_____ |

Are you taking any herbal preparations? (St. John's Wort, etc.) Yes No

If yes, list _____

What is your daily consumption of alcohol? _____

Do you wear contact lenses? Yes No

Have you had cold sores or fever blisters? Yes No

Mark your skin type (when exposed to the sun for about 1 hour with no protection):

- | | | |
|-----|------------------------------------|--------------------------|
| I | Always burns, never tans | <input type="checkbox"/> |
| II | Always burns, tans with difficulty | <input type="checkbox"/> |
| III | Sometimes burns, tans average | <input type="checkbox"/> |
| IV | Rarely burns, tans with ease | <input type="checkbox"/> |
| V | Moderately pigmented | <input type="checkbox"/> |
| VI | Black | <input type="checkbox"/> |

When were you last exposed to the sun (or a tanning booth)? _____

Do you use bronzers, self tanners or chemical sun tanning lotions? Yes No

Are you planning significant sun exposure in the next 2 weeks? Yes No

Have you ever had laser treatments or chemical peels? Yes No

What other skin care treatments have you had in the past? _____

Have you ever had treatments for pigmented lesions? Yes No

Prior treatment (if any) _____

Have you had any surgical or medical treatments on the area we will be treating?

Patient Signature _____

Date _____