New Image
LASER SKIN CENTER

Client Medical History

Name_____

Address_____

City_____ State_____ Zip Code_____

Preferred method of contact: _____Home Phone _____Cell Phone _____Work Phone _____E-mail

Home Phone_____ Cell Phone_____

Work Phone _____ E-Mail_____

I would like to subscribe to the New Image Laser Skin Center e-mail program to receive notices about practice news, promotions and events _____Yes _____No

Age_____ Date of Birth_____

How did you hear about New Image? If you were referred by an individual please specify.

_____

What type of problem(s) are you consulting for:

_____Skin Discoloration _____Acne Scarring _____Spider Veins _____Fine Lines

_____Flushing of the Skin _____Large Pores _____Skin Laxity _____Blackheads/ Whiteheads

_____Unwanted Hair _____Acne _____Skin Roughness _____Excessive Oiliness

_____Wrinkles _____White Spots _____Scarring _____Other (please specify)

_____CoolSculpting _____

How many years have you noticed the problem(s)?_____

Are your present skin problems getting more pronounced? _____Yes _____No

Have you ever been treated for the problems? _____Yes _____No When? _____

By what method(s)? _____

Are you currently taking medication for your skin problem? ____Yes _____No

If yes, which medication(s)?_____

Are you pregnant, nursing or planning a pregnancy soon? _____Yes _____No

Do you have a history of keloid scarring? _____Yes _____No

Do you have a history of:

_____Heart disease _____Diabetes _____Fever Blisters 3 ____Skin injury

_____Bleeding disorders _____Bruising _____Auto-immune disorder

_____Dark spots after pregnancy _____Skin cancer or suspicious moles

Have you had any allergic reactions to anesthesia? _____Yes _____No

Do you have any skin related allergies (including latex)? _____Yes _____No

If yes, please specify: _____

Do you take any medication?

_____Aspirin _____Tranquilizers

_____Hormones/contraceptives _____Insulin

_____Thyroid medication _____Appetite depressant (diet pills)

_____Sedatives _____Anti-coagulants (blood thinners)

_____Cortisone _____Other (please specify)

_____

Do you have any allergies to medication? _____Yes _____No

If yes, please specify: _____

Are you taking any herbal preparations? (St. John's Wort) _____Yes _____No

If yes, list_____

What is your weekly consumption of alcohol?_____

Are you a smoker? _____No _____Yes/How many years?_____

Do you wear contact lenses? _____Yes _____No

Have you had cold sores or fever blisters? _____Yes _____No

Describe your skin: _____Dry _____Combination _____Oily _____Normal

Please check the skincare products you currently use and list their brand names:

____Facial Cleanser_____ ____Moisturizer_____

____Exfoliating Scrub_____ ____Night Moisturizer_____

____Toner_____ ____Eye Cream_____

____Growth Factors_____ ____Sun Protection_____

____Retinol_____ ____Makeup_____

____Antioxidant_____ ____Other_____

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

Do you regularly tan outside or in a tanning booth? _____Yes _____No

Do you use chemical sun tanning lotions? _____Yes _____No

Are you planning a vacation in the sun? _____Yes _____No

Have you ever had skin resurfacing, rejuvenation or chemical peels? _____Yes _____No

Have you ever had treatments for pigmented lesions? _____Yes _____No

Prior treatment (if any)_____

Client Signature_____ Date_____