# NEW CLIENT PAPERWORK

LASER, IPL, RADIOFREQUENCY PROCEDURE MEDICAL HISTORY FORM

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: (*paperwork and offers*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who can we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please answer the following questions. All information is confidential.*

**General:**

Are you currently under the care of a physician? Yes/No If yes, for what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medical Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past medical conditions (cancer, IBS, asthma, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications (including hormones and birth control): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements and over the counter medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies to any drugs, foods or substances (latex, metals, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other beauty concerns or goals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aesthetic Procedures:**

*CIRCLE ANY THAT APPLY:*

Pregnant or breastfeeding / bleeding disorder / diabetes / skin cancer (past or present) / cancer / autoimmune disease / skin condition / heart disease (arrhythmia etc.) / anti-coagulant meds / liver disease / keloid scarring /poor skin healing / skin numbness / herpes mouth / herpes pelvic / lowered immune system

Easy bruising / fainting / low blood sugar / anxiety / fear of blood, needles, pain / permanent make-up / tattoos / implants / adverse reactions to skin products, procedures, laser, IPL, RF or numbing cream / sensitive skin /low pain tolerance

In the last 6 weeks have you had/taken

Sun exposure, tanning, artificial tan / chemical peels / cosmetic procedures (including Botox etc.) / Retinoic Acid type products / photosensitizing medications (see list)

In the past 6 months have you taken Accutane or something like it? Yes / No

I acknowledge that all information provided is true to the best of my knowledge and I have been truthful to my care professional. If any of this information changes, I will inform my care professional

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**POTENTIALLY PHOTOSENSITIZING MEDICATIONS**

**Acne Meds**

Isotretinoin (Accutane) Tretinoin (Retin-A)

**Anticancer**

Chlorambucil Cyclophosphamide

Dacarbazine Fluorouacil

Flutamide Mercaptopurine

Methotrexate Procarbazine

Thioguanine Vinblastine

**Antidepressants**

Amitriptyline Amoxapine

Clomipramine Doxepin

Imipramine Isocarboxazid

Maprotiline Phenelzine

Protriptyline Trazadone

Trimipramine

**Antiepileptics, Sedative, Muscle Relaxants**

Carbamazepine Cyclobenzaprine

Diazepam Meprobamate

Phenobarbitol Phenytoin

**Antihistamines**

Azatadine Clemastine

Diphenhydramine Terfenadine

Tripelennamine

**Antihypertensives**

Captopril Dilitiazem

Methyldopa Minoxidil

Nifedipine

**Antimicrobials**

Ciprofloxacin Clofazimine

Dapsone Demeclocycline

Doxycycline Enoxacine

Flucytosine Griseafulvin

Ketoconazole Lomefloxacine

Methacycline Minocycline

Nalidixic acid Narfloxacin

Ofloxacin Oxytetracycline

Pyrazinamide

Sulfa Drugs (Bactrim, Septra,Tetracycline)

**Antiparasitics**

Bithionol Chloroquine

Pyruvinium pamoate Quinine

Thiabendazole

**Antipsychotics**

Chlorpromazine Chlorprothixene

Fluphenazine Haloperidol

Perphenazine Prochlorperazine

Promethazine Thioridazine

Thiothixane Trifluoperazine

Thioflupromazine Trimeprazine

**Cardiovascular**

Amiodarone Atenolol

Captopril Diltiazem

Disopyramide Nifedipine

Propranolol Quinidine gluconate

Quinidine sulfate Verapamil

**Diuretics**

Acetazolaminde Amiloride

Bendroflumethiazide Benzthiazide

Chlorothiazide Furosemide

Hydrochlorothiazide Hydro flumethiazide

Methyclothiazide Metalazone

Polythiazide Quinethazone

Trichlormethia-zide

**Hypoglycemics**

Acetohexamide Chlorpropamide

Glipizide Tolazamide

Tolbutamide

**NSAIDS**

Diclofenac Fenoprofen

Flurbiprofen Indomethacin

Ketoprofen Meclofenamate

Naproxen Phenylbutazone

Piroxicam Sulindac

**Others**

Bergamot oil Oils of citron, lavender, lime, sandalwood

Benzocaine Clofibrate Oral contraceptive

Etretinate Gold salts

Hexachlorophene Lovastatin St John’s Wort methylcoumarin (used in perfumes, lotions, etc)

**FITZPATRICK SKIN TYPE FORM**

**Please mark the Score (0-4) and then add the scores on the right side of the page.**

**Genetic Disposition**

What is the color of your eyes?

**0** –Lt blue\Gray\Green **1** – Blue\Gray\Green **2** – Blue **3** – Dark Brown **4** – Brown-Black **Score: \_\_\_\_\_\_**

What is the natural color of your hair?

**0** – Sandy Red **1** – Blonde **2** – Auburn/ light Blonde **3** – Dark Brown **4** – Black **Score: \_\_\_\_\_\_**

What is the color of your skin (non-exposed areas)?

**0** – Reddish **1** – Very Pale **2** – Pale w/Beige Tint **3** – Light Brown **4** – Dark Brown **Score: \_\_\_\_\_\_**

Do you have freckles on unexposed skin?

**0** – Many **1** – Several **2** – Few **3** – Incidental **4** – None **Score: \_\_\_\_\_\_**

 **Total Score for Genetic Disposition: \_\_\_\_\_\_\_**

**Reaction to Sun Exposure**

What happens when you stay too long in the sun?

**0** – Painful red, blistering, peeling **1** – Moderate red, blistering followed by peeling

**2** – Mild burn sometimes followed by peeling **3** – Rare Burns **4** – Never burns **Score: \_\_\_\_\_\_\_**

To what degree do you turn brown?

**0** – Never **1** – Light tan **2** – Reasonable tan **3** – Tan easy **4** – Tans darkly quickly **Score: \_\_\_\_\_\_\_**

Do you turn brown within several hours after sun exposure?

**0** – Never **1** – Seldom **2** – Sometimes **3** – Often **4** – Always **Score: \_\_\_\_\_\_\_**

How does your face react to the sun?

**0** – Sensitive **1** – Seldom **2** – Sometimes **3** – Normal **4** – Resistant **Score: \_\_\_\_\_\_\_**

 **Total score for Reaction to Sun Exposure: \_\_\_\_\_\_\_\_**

**Tanning Habits**

How many months ago was your body last exposed to sun, tanning light or tanning cream?

**0** – More than 3 months **1** – 2-3mo **2** – 1-2mo **3** – Less than 1mo **4** – 2 weeks **Score: \_\_\_\_\_\_\_**

Has the area to be treated ever been exposed to the sun?

**0** – Never **1** – Seldom **2** – Sometimes **3** – Often **4** – Always **Score: \_\_\_\_\_\_\_**

**Total score for Tanning Habits: \_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Skin type score**  |  **Fitzpatrick Skin Type** |

 **0 to 7 I**

 **8 to 16 II**

 **17 to 25 III Total score of 3 sections: \_\_\_\_\_\_\_\_**

 **25 to 30 IV**

 **over 30 V – VI Fitzpatrick SKIN TYPE \_\_\_\_\_\_\_\_**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Client

[Print Name] Signature Date