Washington County Hospital & Medical Group

Patient Sticker

Medical History for Cosmetic Laser Clinic

REASON FOR VISIT (AREA TO BE TREATED):

HAS THIS AREA HAD PREVIOUS LASER, IPL (INTENSE PULSE LIGHT), BOTOX OR FILLERS?

WHEN?

DO YOU HAVE ANY CURRENT OR CHRONIC MEDICAL ILLNESSES? ☐ **YES** ☐ **NO**

DISCLOSE ANY HISTORY OF HEAT URTICARIA, DIABETES, AUTOIMMUNE DISORDERS 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: ____

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DO YOU HAVE ANY CURRENT OR CHRONIC SKIN CONDITIONS? ☐ **YES** ☐ **NO**

ALSO DISCLOSE ANY HISTORY OF VITILIGO, ECZEMA, MELASMA, PSORIASIS, ALLERGIC DERMATITIS, ANY DISEASES AFFECTING COLLAGEN INCLUDING EHLERS-DANLOS SYNDROME, SCLERODERMA, SKIN CANCER, OR ANY OTHER SKIN CONDITION.
PLEASE LIST: ____

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ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? IF SO, FOR WHAT REASON? ☐ **YES** ☐ **NO**

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CURRENT MEDICATIONS (INCLUDING HERBAL MEDS):

Medication	Dose	Frequency

Medication	Dose	Frequency

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MEDICAL HISTORY: CHECK BOX IF APPLICABLE			
☐ ANY allergies to medications, foods, latex or other substances. Please list: ____________________ ☐ History of keloid scanrring or hypertropic scar formation ☐ Irregular menstrual periods, or diagnosed with Polycystic Ovary Disorder ☐ Used Botulinums, such as Botox© or Dysport© Please list locations on body and date: ______________ ☐ Unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks.	☐ History of herpes I or II in the area to be treated? ☐ Are you pregnant? ____Yes ____No ☐ Have permanent make-up, tattoos, implants, retainers or fillers, including, but not limited to collagen, autologous fat, Restylane©, etc. Please list locations on body and date: ______________ ______________________	☐ History of light induced seizures ☐ Open sores or lesions ☐ History of radiation therapy in the area to be treated ☐ Taken anticoagulants or blood thinners in the last 6 months. Please list and date last used: ______________________ ______________________ ☐ Taken Tretinoin (like Retin-A©, Renoval©) in the last six months.	☐ Use glocolic acid or other alphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments. Please list and date last used: ______________________ ______________________ ☐ Taken Accutaine© (or products containing isotretinoin) in the last 12 months

____ PROVIDER SIGNATURE

________________________ DATE