



**Patient Medical History**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Circle one: Male or Female

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_

Please list any medications, including prescription and/or over-the-counter medicines you are presently taking (oral and topical): \_\_\_\_\_  
\_\_\_\_\_

Please list any past/present medical conditions or surgeries: \_\_\_\_\_  
\_\_\_\_\_

List previous types of hair removal used for the area(s) you want treated (e.g. waxing, electrolysis, shaving, depilatories, laser, etc.): \_\_\_\_\_

When: \_\_\_\_\_

List previous types of laser procedures (e.g. photofacial, vein, hair removal, acne, rosacea, hyperpigmentation, etc.): \_\_\_\_\_

When: \_\_\_\_\_