DERRINGTON
Dermatology

MEDICAL HISTORY FORM – LASER TREATMENT

Last Name:____________________ First Name:____________________

City:____________________ State:______________ Zip Code:______________

Telephone: Home:______________ Work:______________ Cell:______________

Date of Birth:______________ Sex: Female__________ Male__________

Family Doctor:____________________ Phone:____________________

Pharmacy:____________________ Phone:____________________

Emergency Contact:____________________ Phone:____________________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

YES NO

1. Do you have **ANY** current or chronic medical illnesses we should know about? ☐ ☐

   Please list:____

   ____

2. Are you currently under a doctor's care? If so, for what reason?______________ ☐ ☐

   ____

3. Do you take/use **ANY** medications, herbal or natural supplements or topicals on a regular or daily basis? ☐ ☐
   Please list:____

   ____

4. Do you have **ANY** allergies to medications, foods, latex or other substances? ☐ ☐
   Please list:____

   ____

MEDICAL HISTORY

YES NO

5. (For women) are you or could you be pregnant? ☐ ☐
6. (For women) are menstrual periods regular? ☐ ☐
7. Do you have a history of herpes I or II in the area to be treated? ☐ ☐
8. Do you have a history of keloid scarring? ☐ ☐
9. Have you taken Accutane or anticoagulants in the last 6 months? ☐ ☐
10. Do you have any permanent make-up, implants, or tattoos? ☐ ☐

    If yes, please list locations:____

    ____

11. Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? ☐ ☐
12. Which body area/areas or condition would you like treated?______________________
13. Do you have a history of seizures? ☐ ☐
14. Are you light sensitive? ☐ ☐

Signature:____________________________ Date:____________________