

O'Leigh Med Spa & Laser Center: New Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Date of Birth _____ Age _____ Referred by _____

Area(s) to be treated _____

Heath History for Laser Treatments

What medications are you taking (including aspirin)? _____

Are you taking any herbal preparations (St. John's Wort, etc)? _____

Allergies: _____

Please check off if you currently have, or have ever had, these medical conditions:

- | | |
|--------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Bleeding disorder, or easy bruising | <input type="checkbox"/> Endocrine or hormone issues |
| <input type="checkbox"/> Pigmentation disorder | <input type="checkbox"/> Pacemaker / defibrillator |
| <input type="checkbox"/> History of cold sores | <input type="checkbox"/> Accutane within 6 months |
| <input type="checkbox"/> History of keloid scarring | <input type="checkbox"/> History of skin cancer |
| <input type="checkbox"/> Dermatological conditions | <input type="checkbox"/> Photoallergic |

Do you have any active infections? Yes No Are you pregnant? Yes No

When exposed to the sun without protection for about 1 hour, how does your skin react?

- always burns, never tans
- always burns, sometimes tans
- sometimes burns, sometimes tans
- always tans
- Hispanic, Asian, Mediterranean, Middle Eastern
- Black

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

Do you use chemical sun tanning lotions? Yes No Do you smoke? Yes No

What is your daily consumption of alcohol? _____

Prior treatment (if any) _____