LA SIGHT

COSMETIC HISTORY

NAME _____ DATE _____

CONTACT INFORMATION			
Name:	Cell Phone:		DOB:
Email:	Home Phone:		Age:
Address:	City:	State:	Zip:
Emergency Contact:	Emergency Phone:		

CURRENT HEALTH					
Allergies?					
Are you currently being treated for any medical condition?					
Smoke? How Much?	YES	NO	Pregnant or breast feeding?	YES	NO

SKIN HISTORY					
Acne/Acne scarring	YES	NO	Unwanted hair	YES	NO
Skin laxity	YES	NO	Brown spots/sun damage	YES	NO
Pigmented lesions	YES	NO	Skin texture/scars	YES	NO
Spider veins	YES	NO	Rosacea	YES	NO
Flushing of the skin	YES	NO	Fine lines & wrinkles	YES	NO
Crows feet	YES	NO	Dry skin	YES	NO
Large pores	YES	NO	Deep lines/shadows	YES	NO
Recent skin peel?	YES	NO	If yes, how long ago?		

COSMETIC HISTORY			
	Date	**Area**	**Adverse Reaction?**
BOTOX or similar			
Dermal fillers			
Collagen or Fat			
Other: _____			

LASIGHT

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SUPPLEMENTS & MEDICATIONS					
Have you taken any of the following in the last 7 days?					
Aspirin	YES	NO	Accutane	YES	NO
Thyroid Medication	YES	NO	Anticoagulants	YES	NO
Retina A Cream	YES	NO	Hydroquinone	YES	NO
Cortisone or steroids	YES	NO	Non-steroidal anti-inflammatory (Advil, Aleve, Celebrex)	YES	NO
Ginko Biloba	YES	NO	Vitamin A	YES	NO
Vitamin E	YES	NO	Garlic	YES	NO
Flaxseed oil	YES	NO	St John's Wort	YES	NO
Please list all medications, including antibiotics:					

MEDICAL HISTORY					
Anaphylaxis reaction	YES	NO	Bleeding disorder	YES	NO
Severe allergic reactions	YES	NO	Keloid	YES	NO
Hyperpigmentation	YES	NO	Hives	YES	NO
Immunosuppressive therapy	YES	NO	Diabetes	YES	NO
Skin cancer	YES	NO	Cold sores	YES	NO

ACKNOWLEDGEMENT

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire.

YOUR SIGNATURE: _____ **PRINT NAME:** _____