Medical History Questionnaire

Patient Name: _____ Date: _____

How would you rate your overall health? ____good _____fair _____poor

Medical History: *(Do you have now, or have you ever had any of these diseases or conditions)*

Anesthesia Problems	Yes No	Diabetes	Yes No	Kidney Disease	Yes No
Anxiety	Yes No	Dizzy Spells/Fainting	Yes No	Liver Disease	Yes No
Arthritis	Yes No	Eczema	Yes No	Lung Disease	Yes No
Asthma/Wheezing	Yes No	Headaches	Yes No	Melanoma	Yes No
Autoimmune Disease (RA, Lupus)	Yes No	Heart Attack	Yes No	Neurological Disease (MS, etc)	Yes No
Bleeding Problems	Yes No	Heart Disease	Yes No	Pacemaker/Defibrillator	Yes No
Blood Clots	Yes No	Hepatitis	Yes No	Psychiatric Conditions	Yes No
Bone Marrow Transplant	Yes No	High Blood Pressure	Yes No	Seizures	Yes No
Bruise Easily	Yes No	HIV/AIDS	Yes No	Skin Cancer	Yes No
Cancer	Yes No	Hormone Imbalance	Yes No	Stroke	Yes No
Chest Pain	Yes No	Irregular Heartbeat	Yes No	Thyroid Problems	Yes No
Cold Sores/Herpes	Yes No	Irregular Moles/Growths	Yes No	Tuberculosis	Yes No
Depression	Yes No	Keloid scar	Yes No		

If yes on any of the above, please explain: _____

List any other disease or conditions we should know about: _____

List any surgical procedures you have had in the past 5 years: _____

Medications: *(Are you taking any of the following?)*

Antibiotics	Yes No	Blood Pressure Medicine	Yes No	Insulin	Yes No
Anti-depressants	Yes No	Blood Thinners	Yes No	NSAIDS (Ibuprofen, Motrin)	Yes No
Anti-anxiety medication	Yes No	Coumadin (Warfarin)	Yes No	Sedatives	Yes No
Anti-seizure medication	Yes No	Herbal Preparations/Vitamins	Yes No	Steroids (Prednisone, etc)	Yes No
Aspirin	Yes No	Hormones	Yes No	Thyroid medication	Yes No
Birth Control	Yes No				

Do you have Metal implants? Yes No If yes, where? _____

Do you have Artificial Joints? Yes No If yes, where? _____

Medications: (Please list Prescriptions, Over-the-Counter Drugs, Topicals, Vitamins, Supplements, and Herbs)

_____

_____

_____

Allergies:

Benzocaine	Yes No	Drug Allergies	Yes No	Latex Allergy	Yes No
Lidocaine	Yes No	Environmental Allergies	Yes No	Sensitivity to Smells	Yes No
Tetracaine	Yes No	Food Allergies	Yes No	Phenylephrine	Yes No

If yes to these or any other allergies, please list specific allergen and reaction:_____

Female Patients Only:

Pregnant	Yes No	Breast Feeding	Yes No	Trying to conceive in the next 6mos	Yes No
Using birth control	Yes No				

Skin Disease History:

Acne	Yes No	Eczema	Yes No	Skin Infection	Yes No
Skin Cancer	Yes No	Melanoma	Yes No	Sunburn	Yes No
Precancerous Moles	Yes No	Psoriasis	Yes No	Rosacea	Yes No
Rash	Yes No	Scars/Keloid scars	Yes No	Other	Yes No

If yes, please explain: _____

Do you currently or have you ever used any of the Retinoid products?

Accutane	Yes No	Hydoquinone	Yes No	Retin-A	Yes No
Adapalene	Yes No	Renova	Yes No	Tretinoin	Yes No
Glycolic acid	Yes No	Other: _____			

Do you wear sunscreen? Yes No If yes, what SPF and brand? _____

When was your last sun exposure (outdoors, tanning salons/tanning lotions)? _____

Do you have any Tattoos or permanent makeup? Yes No

Do you Tweeze, wax, shave, or had electrolysis? Yes No If yes, when and where? _____

Have you ever had any of the following?

Botox/Dysport	Yes No	Facial Surgery	Yes No	Laser Procedures	Yes No
Chemical Peels	Yes No	Dermal Fillers	Yes No	Microdermabrasion	Yes No
Face Lift	Yes No	Hair Removal	Yes No	Microneedling	Yes No

Other: _____

If yes to any of the above, what is the date of the last treatment/s?
_____

To help us determine a treatment plan suitable for you, please describe your skin type *(check all that apply)*

____ Thick	____ Normal	____ Small Pores	____ Mature/Wrinkled
____ Thin	____ Oily	____ Freckled/Sun Damaged	____ Hypo/hyperpigmentation
____ Saggy	____ Dry	____ Uneven Skin Tone	____ Acne Scarred
____ Firm	____ Prone to Breakouts	____ Melasma	
____ Sensitive	____ Large Pores	____ Broken Capillaries	

Patient Consent Agreement:

I affirm that I have stated all my known medical conditions/allergies and have answered all questions honestly. I agree to keep the provider updated as to any changes in my personal/medical profile and understand that there shall be no liability to Elysium Skin & Laser should I fail to do so. Complications are rare. Should post procedure complications arise necessitating care at a medical or emergency facility, clients are responsible for any and all charges incurred.

I understand all treatments at Elysium Skin & Laser are considered cosmetic and are completely voluntary and not covered by insurance. Although positive results are expected, there is no guarantee or warranty, expressed or implied of outcome results or patient satisfaction that may be obtained for any service or treatment performed at Elysium Skin & Laser. Although highly unlikely, it is possible that you may not experience any noticeable results from treatments. I understand there are no specific guarantees concerning expected treatment results. I understand that with any treatment certain risks, complications or side effects from known or unknown causes could occur. I freely assume these risks and acknowledge and agree to hold Elysium Skin & Laser and its employees harmless against any and all expenses, liability and claims.

I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. Payments are due and payable on the day of service. All sales are final. There are no refunds on completed treatment or service sales. Services may be denied if consents and policies are not signed.

Patient's Name (Please Print): _____ **Signature of Patient or Legal Guardian:** _____

Date: _____