



*Azalea Laser  
and  
Skincare*

**New Patient Laser and Skin History**

**Patient Name:** \_\_\_\_\_

<b>Patient Profile History</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Allergies (food or drug) ----- Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you being seen by a physician? ----- Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant or attempting pregnancy? -----	<input type="checkbox"/>	<input type="checkbox"/>	Experienced fertility problems? -----	<input type="checkbox"/>	<input type="checkbox"/>
Do you have signs of menopause? -----	<input type="checkbox"/>	<input type="checkbox"/>	Have you completed menopause? -----	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a hysterectomy? -----	<input type="checkbox"/>	<input type="checkbox"/>	Were your ovaries removed? -----	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormone replacements? ----	<input type="checkbox"/>	<input type="checkbox"/>	Are you a cancer patient? -----	<input type="checkbox"/>	<input type="checkbox"/>
Are you or have you had radiation? ----- Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	Ever diagnosed with skin cancer? ----- Where? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any recent surgeries? ----- Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Implants, tattoos, permanent make-up? ----	<input type="checkbox"/>	<input type="checkbox"/>
Smoker? -----	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____		
Have you ever had a chemical peel? -----	<input type="checkbox"/>	<input type="checkbox"/>	Do you sunbath or use tanning beds? ----- How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any injectables? ----- Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you use sunscreen/sunblock? -----	<input type="checkbox"/>	<input type="checkbox"/>

**Do You Have A History Of Any Of The Following Conditions?**

Diabetes -----	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion -----	<input type="checkbox"/>	<input type="checkbox"/>	Malignancies -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease -----	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex I, II, or III -----	<input type="checkbox"/>	<input type="checkbox"/>
Seizures -----	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C -----	<input type="checkbox"/>	<input type="checkbox"/>
HIV -----	<input type="checkbox"/>	<input type="checkbox"/>	AIDS -----	<input type="checkbox"/>	<input type="checkbox"/>
STD's -----	<input type="checkbox"/>	<input type="checkbox"/>	Keloids -----	<input type="checkbox"/>	<input type="checkbox"/>
Metal Plates -----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid -----	<input type="checkbox"/>	<input type="checkbox"/>
Neurological -----	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome -----	<input type="checkbox"/>	<input type="checkbox"/>

**Are you Currently Taking Any Of The Following Medications?**

Testosterone -----	<input type="checkbox"/>	<input type="checkbox"/>	Anabolic Steroids -----	<input type="checkbox"/>	<input type="checkbox"/>
Aldactone -----	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid -----	<input type="checkbox"/>	<input type="checkbox"/>
Minoxidil -----	<input type="checkbox"/>	<input type="checkbox"/>	Retin-A/Retinol -----	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy -----	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners -----	<input type="checkbox"/>	<input type="checkbox"/>
DHEA -----	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline -----	<input type="checkbox"/>	<input type="checkbox"/>
NSAIDS -----	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressants -----	<input type="checkbox"/>	<input type="checkbox"/>
Doxycycline -----	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics -----	<input type="checkbox"/>	<input type="checkbox"/>
Accutane -----	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control -----	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other medications you are presently taking: \_\_\_\_\_

**How Would You Best Describe Your Skin?**

Oily       Dry       T-Zone       Combination       Normal       Seasonal  
 Acne Prone       Sensitive       Active Acne       Pigmentation       Environmental Damage

**Race:**  Caucasian     Asian     Hispanic     African American     Indian     Other \_\_\_\_\_

**Patient's Main Concerns:**

Hair Removal     Lines/Wrinkles     Skin Texture     Acne     Acne Scars     Even Color Tone  
 Skin Elasticity     Melasma     Facial Veins     Leg Veins     Birth Marks     Stretch Marks  
 Millia     Keratosis     Keloids     Enlarged Pores     Other \_\_\_\_\_