ATOKA SKIN LASER CENTER, LLC
901-840-3871

MEDICAL HISTORY FORM

Patient Name ______________________________ Date ______________

Date of Birth __________ Age ______ Sex ___M ___F Height ______ Weight ________

General Medical History: Do you or have you ever had any of the following problems? Circle Y for yes, N for no

Bronchitis	Y	N	Diabetes	Y	N
Emphysema'	Y	N	Thryoid	Y	N
Asthma	Y	N	Herpes, mouth	Y	N
Kidney or bladder	Y	N	Herpes, genitals	Y	N
Chronic cough	Y	N	Basal or squamous cell	Y	N
Morning cough	Y	N	Cancer	Y	N
Shortness of breath	Y	N	Melanoma	Y	N
Wheezing	Y	N	Arthritis/joint deformity	Y	N
High blood pressure	Y	N	Fainting	Y	N
Blood clot	Y	N	Convulsions, epilespy, seizures	Y	N
Chest pain	Y	N	Neurological disease	Y	N
Pacemaker/defibrillator	Y	N	Rosacea or acne	Y	N
Heart attack	Y	N	Thinning lashes	Y	N
Heart murmur	Y	N	Onychomycosis/nail fungus	Y	N
Irregular heartbeat	Y	N	Pregnant or breast feeding	Y	N
Phlebitis	Y	N	Plan on being pregnant	Y	N
Inflammation of veins	Y	N	Ingrown hairs	Y	N
HIV or AIDS	Y	N	Irritation from shaving	Y	N

Current and/or recent medications: ______________________________

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Allergies to medications: ______________________________

Prior Cosmetic Procedures:	Circle Y for Yes, N for No				
Botox	Y	N	Microdermabrasion	Y	N
Fillers (Juviderm, Collagen, etc)	Y	N	Intense Pulse Light Rejuvination	Y	N
Laser Resurfacing	Y	N	Laser Hair Removal	Y	N
Chemical Peels	Y	N	Laser Vein treatment	Y	N

Please Circle the procedures that you would like more information on: **Laser hair removal** **Dermal Fillers**
Botox **Laser Skin Resurfacing** **Brown spots/Sun Damage** **Skincare Products** **Chemical Peels**

Use of RetinaA or topical retinoids	Y	N	Are you currently using Accutane?	Y	N
History of use of Accutane?	Y	N	Do you routinely use sunscreen ?	Y	N SPF ____

Social History:
Do you smoke or use tobacco? Y N Do you drink alcohol? Y N
per day ____ # per week ____ # per month ____

Marital Status: ______ Children: ______ Hobbies: __________ Occupation: __________

What type of skincare products do you currently use for your face and body? ____________________

Are you currently under the care of a dermatologist? Y N If yes, why? ____________________

Patient Signature: ____________________ **Date:** ____________________
Reviewed By: ____________________ **Date:** ____________________