Lasers • Facial Rejuvenation • Prescription Skin Care

PATIENT INFORMATION/MEDICAL HISTORY

Name:_______________________________________ Date:______________ Age:_________

Address:____
Street City State Zip Code

Phone: Home:_____________________ Work:______________________Cell:_________________

Date of Birth:_____________________ Marital Status:__________

Email Address:____

Occupation:____

Emergency Contact:____________________________ Relationship:___________________
Phone: Home:__________________ Work:________________ Cell:_____________

Health History

Medications: (prescription) Reason for taking:

_______________________________________ ______________________________

_______________________________________ ______________________________

_______________________________________ ______________________________

Over The Counter Medications or Supplements taken in the last 5 days: (Please include vitamins, herbal medications, including aspirin, Ibuprofen, fish oil, Vitamin E)

____
____

Are you taking Aspirin? ❏ Yes ❏ No Are you taking St.John wort? ❏ Yes ❏ No

Are you taking Doxycycline or Tetracycline? ❏ Yes ❏ No

Allergies: (such as Lidocaine, Sulfas, Penicillins or other antibiotics):_______________________________

Any Facial Surgeries/Dates:____
____

For Office Use Only

Signed up for Brilliant Distinctions ❏ Yes ❏ No BD Code or PW_____________________________
Visia Consultation Performed ❏ Yes ❏ No
Before Photos Taken ❏ Yes ❏ No With Make-Up Without Make-Up
Referral Discount Given ❏ Yes ❏ No Referral Credit Given ❏ Yes ❏ No

Patient Name:_________________________________

Do you have a history of?

Acne	❑ Yes ❑ No
Anemia/Blood disorder	❑ Yes ❑ No
Asthma	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No
Bleeding Tendency	❑ Yes ❑ No
Skin Cancer	❑ Yes ❑ No
Other Cancer	❑ Yes ❑ No If so, what type?_______________
When?__________	
Cold Sores/Fever Blisters	❑ Yes ❑ No
Colitis	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No
Defibrillator	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No
Poor Wound Healing	❑ Yes ❑ No
Hay Fever /Seasonal Allergies	❑ Yes ❑ No
Keloids/Abnormal Scars	❑ Yes ❑ No
Easy Bruising	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No
Kidney Disease	❑ Yes ❑ No
Migraine Headaches	❑ Yes ❑ No
Mental Illness	❑ Yes ❑ No
Pigmentation Problems	❑ Yes ❑ No
Rosacea	❑ Yes ❑ No
Suicidal tendency	❑ Yes ❑ No
Neuro-muscular Disease	❑ Yes ❑ No
Thrombosis or Phlebitis	❑ Yes ❑ No
Auto-immune Disorders	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No
Liver Disease	❑ Yes ❑ No
Other Medical Problems	____
Any Metal Implants	❑ Yes ❑ No
Are you pregnant?	❑ Yes ❑ No
Are you breastfeeding?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No

Do you drink Alcohol ❑ Yes ❑ No How much?________________ When was your last drink of alcohol?______________________

Have you ever taken Accutane? ❑ Yes ❑ No If so, when?______________________

Any active infection? ❑ Yes ❑ No

Do you have any disorders stimulated by light, such as recurrent Herpes Simplex, Systemic Lupus Erythematosus or Porphyria? ❑ Yes ❑ No

Do you have a history of Immunosuppressive diseases, including AIDS, HIV, or use of immunosuppressive medications? ❑ Yes ❑ No

Do you have a history of hormonal or endocrine disorders, such as polycystic ovary syndrome or disease? ❑ Yes ❑ No

Have you had significant exposure to the sun, artificial tanning or used self-tanners in the last 4 weeks? ❑ Yes ❑ No

Do you wear a sunscreen everyday? ❑ Yes ❑ No If so, what is the SPF?____________
Does it have at least 9% zinc oxide or titanium dioxide? ❑ Yes ❑ No ❑ I'm not sure.

Skin type (when exposed to the sun without protection for about 1 hour) Please circle:

- Always burns, never tans
- Always burns, sometimes tans
- Sometimes burns, sometimes tans
- Always tans
- Hispanic, Asian, Mediterranean, Middle Eastern, or American Indian Descent
- Black

I would like to discuss with Dr. Comeau today issues regarding:

❑ Aging Chest/Neck	❑ Hand Veins	❑ Sagging/Loose skin	❑ Wrinkles
❑ Aging Skin-Face	❑ Hyperhidrosis (Sweating)	❑ Scars	❑ Acne Treatment
❑ Crows Feet	❑ Lip Enhancement	❑ Smile Lines	❑ Short Lashes
❑ Frown Lines	❑ Pigmentation Problems	❑ Spider Veins	❑ Skin Care
❑ Hair Removal	❑ Rosacea	❑ Sun Damage	❑ Other

Have you had any prior aesthetic medicine treatments? (Botox, Filler, Laser, etc.)___________________

____

Patient Name:________________________________

I am interested in hearing more about:

❏ Botox/Dysport	❏ Skin Resurfacing	❏ Medical Grade Skin Care
❏ Facial Fillers	❏ Rosacea Treatment	❏ Acne Treatment
❏ Laser Hair Reduction	❏ Skin Tightening	❏ Fractionated CO2
❏ Photorejuvenation (IPL/ BBL)	❏ Latisse	❏ Vein Treatment

How did you hear about us?____

The above information is true and accurate to the best of my knowledge.

____ ________________

Patient Signature Date

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