NEW PATIENT FORM

Patient Name:_____
Address: _____ City: _____ TX, Zip: _____
Home Ph:_____ Cell: _____ Wk: _____
Date of birth: _____ Sex: Male Female _____

Medical History

Have you ever had the following?

- Current or history of cancer, if so what: _____
- Any active infection or broken skin, if so what? _____
- Diseases which may be stimulated by light such as a history of Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria ❑
- Use of photosensitive medication and or herbs that cause sensitivity to light exposure such as Isotretinoin, tetracycline, or St Johns Wort. ❑
- Immunosuppressive diseases, including AIDS and HIV infection or use of immunosuppressive medications. ❑
- History of hormonal or endocrine disorders such as polycystic ovary syndrome or diabetes. ❑
- History of bleeding coagulopathies, or use of anticoagulants ❑
- History of keloid scarring ❑
- Pacemaker/defibrillator ❑
- Accutane w/in last 6 mths ❑
- Fragile/intolerant skin ❑

Are you pregnant?
What medications are you taking? _____
_____

What herbal preparations are you taking? _____
Do you wear contact lenses?

Skin Type (when exposed to the sun without protection for about an hour?)

- Always burns, never tans ❑
- Always burns, sometimes tans ❑
- Sometimes burns, sometimes tans ❑
- Always tans ❑
- Hispanic ❑ Asian ❑ Mediterranean ❑ Middle Eastern ❑ Indian ❑ Black ❑ Caucasian ❑
- When were you last exposed to the sun or artificial tanning?_____

Reason for visit: _____
_____
Prior treatment, if any: _____