



## PATIENT QUESTIONNAIRE

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
How did you hear about Miami Beach Laser Spa? \_\_\_\_\_  
In case of emergency, whom should we contact? \_\_\_\_\_  
Phone: \_\_\_\_\_

### MEDICAL HISTORY

Have you ever had (please check all that apply):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease                 | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Eye conditions |
| <input type="checkbox"/> Heart attack or chest pain    | <input type="checkbox"/> Easy bleeding or bruising         | <input type="checkbox"/> HIV/AIDS       |
| <input type="checkbox"/> Hypertension                  | <input type="checkbox"/> Delayed or abnormal wound healing |   |
| <input type="checkbox"/> Endocrine or hormone disorder | <input type="checkbox"/> Heart pacemaker or defibrillator  |   |
| <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Current or recent pregnancy       |   |

List any medical problems you have: \_\_\_\_\_

List any medications that you are currently taking, including vitamins and herbals: \_\_\_\_\_

List any medication allergies that you have and the reaction: \_\_\_\_\_

Are you allergic to any metals? \_\_\_\_\_ Are you allergic to latex? \_\_\_\_\_

Do you use any tobacco products? \_\_\_\_\_

### SURGICAL HISTORY

List any operations you have had:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

# PATIENT QUESTIONNAIRE

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### DERMATOLOGIC HISTORY

Have you ever had (please check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic skin conditions                       | <input type="checkbox"/> Skin cancer                                  |
| <input type="checkbox"/> Laser skin resurfacing                        | <input type="checkbox"/> Photosensitivity                             |
| <input type="checkbox"/> Herpes simplex or cold sores                  | <input type="checkbox"/> Chemical peel                                |
| <input type="checkbox"/> Keloid or hypertrophic scar                   | <input type="checkbox"/> Accutane use for acne                        |
| <input type="checkbox"/> Botox injections                              | <input type="checkbox"/> Pigmentation disorder                        |
| <input type="checkbox"/> Tetracycline use for acne                     | <input type="checkbox"/> Injection of collagen or other dermal filler |
| <input type="checkbox"/> Recent waxing or plucking                     | <input type="checkbox"/> Electrolysis or threading                    |
| <input type="checkbox"/> Recent sunburn or tan (including tanning bed) |   |

What is your ethnic background? \_\_\_\_\_

When exposed to the sun, do you usually:  Always burn, never tan  
 Burn easily, tan poorly  Tan after initial burn  Burn minimally, tan easily  
 Rarely burn, tan darkly easily  Never burn, always tan darkly

Do you use Sunscreen regularly? \_\_\_\_\_ What SPF are you using? \_\_\_\_\_

Do you use artificial or "sunless" tanning products? \_\_\_\_\_

List any special skin care products you use: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_