Valley View Laser M.D.
PHYSICIAN DIRECTED

Medical History and Skin Care Questionnaire

Name__________________________ Date__________

Birthdate______________ Age______ Sex _____ Phone Number______________

Please check if you have/have had any of the following:

- ☐ Cold sores/fever blisters/herpes
- ☐ Photosensitive disorder
- ☐ Keloids
- ☐ Excessive scarring
- ☐ Hives
- ☐ Sensitive skin
- ☐ Seizures
- ☐ Migraines
- ☐ Hormonal imbalance/menopause
- ☐ Autoimmune disorders

Please list your past medical history ______________________________

Please list any current medications you are taking ______________________________

Please list all known allergies to medications/foods/ingredients ______________________________

What is your natural hair color? ______________________________

Have you ever had a reaction to skin products/treatments before? ______________________________

Please circle yes or no

Smoker?	yes/no
Do you use tanning beds?	yes/no
Do you burn easily?	yes/no
Do you tan easily?	yes/no
Use of tanning lotion in the past 8 weeks?	yes/no
History of skin cancer?	yes/no
Use of Retin-A?	yes/no
Use of Accutane?	yes/no
Previous skin infections?	yes/no
Use of a skin lightener?	yes/no
Pregnant?	yes/no

Do you use sunscreen?

- ☐ Always
- ☐ Sometimes
- ☐ Never

History of sun exposure?

- ☐ Minimal
- ☐ Moderate
- ☐ Excessive

I certify that the medical, personal, and skin history statements listed above are true and correct. I am aware that it is my responsibility to inform the doctor, nurse, or technician of my current medical and/or health conditions, and to update this history when there are any changes. I understand that a current medical history is essential to execute appropriate treatment procedures and that the correct information maximizes my results.

Signature of Patient ______________________________ Date __________

Signature of Guardian ______________________________ Date __________
(if under 18)

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