

# Aesthetic Medicine of New Hampshire

(603) 224-0808 AesMed.com

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F Driver's License # \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Nearest Relative's Name and Phone \_\_\_\_\_

How did you hear about Aesthetic Medicine of NH? \_\_\_\_\_

## MEDICAL HISTORY

1.) Please list all of the medical problems you have had in the past.

\_\_\_\_\_

2.) Have you ever had or currently have any of the following:

Diabetes	Yes	No	A bleeding disorder	Yes	No
Vein Problems	Yes	No	Keloids (raised scar)	Yes	No
Skin Cancer	Yes	No	Rheumatoid Arthritis	Yes	No
Lupus	Yes	No	Autoimmune Disease	Yes	No
Pacemaker	Yes	No	Defibrillator	Yes	No

Allergies \_\_\_\_\_

Skin Sensitivities \_\_\_\_\_ Nickel sensitivity Yes No

Additional Information, if any \_\_\_\_\_

3.) Your Physician's Name \_\_\_\_\_

4.) What meds are you taking? \_\_\_\_\_

5.) Have you taken aspirin or aspirin-type meds (Ibuprofen, Advil, Motrin, Aleve, Bufferin, Orudis, Pepto-Bismol, etc.) within the last 10 days? Yes No

6.) Are you pregnant? Yes No Breast-feeding? Yes No

7.) Do you have any tattoo's or permanent make-up in the area to be treated?  
If "yes" please specify \_\_\_\_\_

8.) Have you ever been treated by an Endocrinologist? If yes, please explain your condition \_\_\_\_\_

9.) HOW OFTEN DO YOU SUN BATHE OR VISIT A TANNING BOOTH?  
\_\_\_\_\_ Frequently \_\_\_\_\_ Sometimes \_\_\_\_\_ Never

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NAME \_\_\_\_\_

10.) WHEN WAS THE LAST TIME YOUR HAD OVER 15 MINUTES OF SUN EXPOSURE? \_\_\_\_\_

11.) DO YOU WEAR SUNSCREEN? Yes No

12.) WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

\_\_\_\_\_ Always burns                      \_\_\_\_\_ Usually burns, sometimes tans  
\_\_\_\_\_ Sometimes burns, usually tans      \_\_\_\_\_ Always tans

13.) WHAT IS YOUR SKIN COLOR?

\_\_\_ Very Pale \_\_\_ Pale with beige tint \_\_\_ Light brown \_\_\_ Olive \_\_\_ Dark brown

14.) WHAT IS YOUR NATIONALITY OR ETHNIC BACKGROUND (Information used for skin typing)?  
\_\_\_\_\_

15.) REVIEW THE FOLLOWING AND CHECK NEXT TO ANY TREATMENTS YOU HAVE HAD OR PRODUCTS YOU ARE USING OR HAVE USED IN THE PAST 12 MONTHS.

\_\_\_\_\_ chemical Peels                      \_\_\_\_\_ microdermabrasion                      \_\_\_\_\_ Accutane  
\_\_\_\_\_ laser surgery or laser/light treatments                      \_\_\_\_\_ Retin-A/Retinol  
\_\_\_\_\_ sunless tanning lotion                      \_\_\_\_\_ antibiotics

If positive response to any of the above, when? \_\_\_\_\_  
\_\_\_\_\_

16.) WHEN WAS THE LAST TIME YOU: Waxed \_\_\_ Plucked \_\_\_ Other \_\_\_\_\_  
IN THE AREA TO BE TREATED? \_\_\_\_\_

17.) CHECK THE APPROPRIATE BOX NEXT TO ANY CONDITION FOR WHICH YOU HAVE EVER BEEN TREATED.

\_\_\_\_\_ Acne                      \_\_\_\_\_ Cold Sores                      \_\_\_\_\_ Hormonal Imbalances                      \_\_\_ Burns  
\_\_\_\_\_ Cancer                      \_\_\_\_\_ Hirsutism                      \_\_\_\_\_ Melanoma                      \_\_\_\_\_ Skin Grafts  
\_\_\_\_\_ Skin Pigmentation                      \_\_\_\_\_ Blood Disorders                      \_\_\_\_\_ Keloids/Scars