

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