

**Arkansas Physical Medicine
Cosmetic Laser Patient History**

Date: _____

Referred by: _____

Name:

Last	First	Middle
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Address:

Street	City	State	Zip
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Telephone: Hm# () _____ Wk# () _____ Cell# () _____

Contact me at: Home Work Cell – Circle one

Age: ____ Date of Birth: _____ Occupation: _____

Cosmetic Procedure(s) I am interested in:

Laser Hair Removal ____	Collagen Rebuilding ____
Leg Veins ____	Permanent Cosmetics ____
Wrinkle Reduction ____	Other _____
Tattoo Removal ____	

Area(s) your interested in treating: __eyebrows__ __Lip__ __Facial__ __Chin__ __Ears__
__Neck__ __Neckline__ __Chest__ __Breast__ __Stomach__ __Bikini Line__ __Thighs__
__Legs__ __Toes__ __Hands__ __Arms__ __Underarms__ __Shoulders__ __Back__
Other _____

HAIR REMOVAL ONLY:

Temporary Removal Attempts: __Shaving__ __Waxing__ __Tweezing__ __Depilatory__
Other _____

How long have you been using the temporary methods? _____

How often do you use the temporary methods? _____

Have you ever had previous __Laser__ __Electrolysis__ If so How many treatments? _____

Is there a history of hair growth problems in your family? __Yes__ __No__

LEG VEINS ONLY:

Have you ever had any veins treated before today? ____

If so what method was used? _____

Have you been diagnosed with Thrombosis? __Yes__ __No__

Have you been seen by a Vascular Surgeon? __Yes__ __No__

MEDICAL HISTORY:

Please check yes or no and list any medication you are taking.

Acne	yes ___	no ___	Medication _____
Aids	yes ___	no ___	Medication _____
Allergies	yes ___	no ___	Medication _____
Blood Pressure	yes ___	no ___	Medication _____
Diabetes	yes ___	no ___	Medication _____
Glandular Disease	yes ___	no ___	Medication _____
Epilepsy	yes ___	no ___	Medication _____

HEART CONDITIONS

Pace Maker	yes ___	no ___	Medication _____
Mitrovalve Prolapse	yes ___	no ___	Medication _____
Heart Murmur	yes ___	no ___	Medication _____
Rheumatic Heart	yes ___	no ___	Medication _____
Heart Surgery _____ Date	yes ___	no ___	Medication _____
Hemophillia	yes ___	no ___	Medication _____
Herpes Simplex 1	yes ___	no ___	Medication _____
Herpes Simplex 2	yes ___	no ___	Medication _____
Hepatitis	yes ___	no ___	Medication _____
Hyper –Hypo pigmentation	yes ___	no ___	Medication _____
Malignancy _____ Date	yes ___	no ___	Medication _____
Treatment _____ Area _____			
Skin Hyper Sensitivities	yes ___	no ___	Medication _____

Any other medical conditions we should know about?

Please list any other medications you are taking:

Women only:

Pregnancies ___yes ___no
 How many _____
 Hysterectomy ___yes ___no
 Partial ___ Complete ___
 Reason _____
 Menstruation Regular ___ Irregular ___
 Date of last pap exam: _____
 Any cystic conditions or tumors? ___yes ___no

I acknowledge that all information contributed by me is true and accurate to the best of my knowledge.

PATIENT SIGNATURE _____

COSMETIC LASER SPECIALIST _____

Notice: All appointments require a 24 hour notice of cancellation. If you fail to call you will be charged with a service fee of \$50.00

Credit Card information:

Card Type: Visa ___ MasterCard ___

Card Number: _____

Exp date: ___ of ___

Billing address if different than home address: _____

City _____ State _____ Zip _____