

Chelsea Skin and Laser
Medical History

Name: _____

Are you currently taking any medications, supplements or homeopathics? Yes No

If so, please list: _____

Are you allergic to any medications? Yes No

If so, please list: _____

Have you ever had or been treated for any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Arthritis, Joint Problems, Bone Disease, Lupus, etc. | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer. If so, what type? _____ | <input type="checkbox"/> Liver or Gall Bladder Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease (Tuberculosis, Pleurisy, other) |
| <input type="checkbox"/> Eye Disease (Glaucoma, Cataracts, other) | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Heart Disease (Rheumatic Fever, Pacemaker, other) | <input type="checkbox"/> Stomach / Intestinal Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |

Is there a history of skin cancer in your family? Yes No

Have you previously had a skin problem? Yes No

If so, please describe: _____

Have you ever been hospitalized or had surgery? Yes No

If so, please provide details and dates: _____

Female Patients: Are you pregnant? Yes No

Taking Birth Control Medication? Yes No

Please inform the doctor if you become pregnant or are planning to become pregnant.

Cosmetic Treatment History (Optional)

Have you had Botox, Fillers or Laser Treatments? Yes No

Are you interested in our special programs? Yes No

Are you concerned about:

- | | |
|---|--|
| <input type="checkbox"/> Forehead wrinkles | <input type="checkbox"/> Improving skin tone and texture |
| <input type="checkbox"/> Wrinkles around the eyes or mouth | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Maintaining a more youthful appearance | <input type="checkbox"/> Red or Blue Leg Veins |
| <input type="checkbox"/> Skin Discolorations | <input type="checkbox"/> Other _____ |

Would you like us to introduce you to a skin care regimen? Yes No

Patient or Guardian

Date