

Women Gynecology and Childbirth Associates, P.C.

Patient Medical History – Laser

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Today's Date: _____

Home Phone: _____ Business Phone: _____

Cell # or Preferred Contact #: _____

Primary Care Physician: _____

Please fill out any of the following that may apply: _____

MEDICAL HISTORY:

Heart Condition: _____ Keloids: _____

Diabetes: _____ Cold Sores: _____

Permanent Makeup / Tattoos: _____ Pregnant or Breastfeeding: _____

Have you been on Accutane or other acne medication in the past 6 months? _____

List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin, etc.): _____

Any Allergies: _____

Acne: Do you have a history of breakouts? _____ Yes _____ No

If so, what is the frequency of your breakouts? __ Frequent __ Occasional __ Rarely

Do you experience cystic breakouts? _____ Yes _____ No

Have you waxed, used depilatories, bleaches or other chemical processes? _____ Yes _____ No

How much water do you normally consume daily? _____

Have you had microdermabrasion? _____ Yes _____ No

Have you had any chemical peels? _____ Yes _____ No

Have you had laser resurfacing? _____ Yes _____ No

Do you have rosacea? _____ Yes _____ No

Do you have wrinkle concerns? _____ Yes _____ No

Do you have scarring concerns? _____ Yes _____ No

Do you have sun damage concerns? _____ Yes _____ No

Do you have pigmentation concerns? _____ Yes _____ No

Do you have broken capillary concerns? _____ Yes _____ No

Have you had Botox or Collagen injections in the past 6 months? _____ Yes _____ No
If yes, and less then 3 months, approximate dates? _____

Do you use topical ointments? _____ Retin-A _____ Glycolic _____ Lactic Acid
_____ Hydroquinone _____ Other: _____

List areas of interest for laser hair removal and any expectations you may have about your results.

How did you hear about us? _____

I certify that the above medical history information is accurate and correct:

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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