Midnight Sun Family Medicine, P.C.
Laser Patient Health Survey

NAME _____ AGE _____ M___ F____ DATE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PREFERRED CONTACT #: _____

Is it important to be discrete? _____ How did you hear about us? _____

Describe the nature of your visit? _____
_____
What are your expectations? _____
_____

Please fill out any of the following that may apply:
Medical History:
Heart Condition: _____ Keloids: _____
Diabetes: _____ Cold Sores/Herpes: _____
Implants or Joint Replacement: _____
Perm Makeup/Tattoos: _____ Pregnant or Lactating: _____
Have you been on Accutane in the past 6 months? _____
Include any other medications that make you photo sensitive: _____
Any allergies? _____
List all medications you are currently taking (blood thinners, antibiotics, herbs, supplements, vitamins, aspirin, etc.)
_____

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
Do you have any scarring as a result from your acne? Yes No

Skin Background:
Have you had prolonged sun exposure (or tanning bed) in the past 3 days? Yes No
If so, are you currently sunburned? Yes No
Do you use tanning beds? Yes No
Are you using chemical tanning solutions? Yes No
Do you use sunscreen on a regular basis? Yes No

Fitzpatrick I-VI:
check one (when exposed to the sun without protection for approximately 1 hour):
_____ (I) Always burns, never tans
_____ (II) Usually burns, tans less than average
_____ (III) Sometimes mild burn, tans about average
_____ (IV) Rarely burns, tans more than average
_____ (V) Rarely burns, tans profusely
_____ (VI) Never burns, deeply pigmented

Skin Type:	**Light**	**Medium**	**Dark**	**Tan**
Caucasian	_____	_____	_____	_____
Asian	_____	_____	_____	_____
Hispanic	_____	_____	_____	_____
Mediterranean	_____	_____	_____	_____
African American	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Have you waxed, used depilatories, bleaches or other chemical processes? _____ Yes _____ No
How much water do you normally consume daily? _____

Do you exercise? _____ Yes _____ No
Do you smoke? _____ Yes _____ No
Do you use recreational substances? _____ Yes _____ No
Do you consume Alcohol? _____ Yes _____ No If so, how often? _____ per week
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 last 6 months? _____ Yes _____ No
If yes and less than 3 months, approximate dates: _____
Do you use topical ointments? _____ Retin-A _____ Glycolic _____ Lactic Acid _____ Hydraquinone
_____ Other: _____
What type of skin care products are you using? _____
_____

Check other services of interest:
_____ Laser Hair Removal (List different areas) _____
_____ Laser Vein Removal, Transdermal/Non-Invasive
_____ Genesis Non-ablative, Collagen Stimulating "Lunch Hour Facelift"
_____ Pigmented Lesions or Brown Spot Removal
_____ truSculpt, Lipolysis Fat Reduction Treatment
_____ Botox
_____ Cosmeceutical Grade Skin Care
  _____ Acne
  _____ Sun Screen
  _____ Sun Damage
  _____ Wrinkle Repair
_____ Longer, Fuller Lash Treatment
_____ Other: _____

I certify that the above medical history information is accurate and correct to the best of my knowledge:

Patient Signature: _____ Date: _____

Dr./Tech Signature: _____ Date: _____