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Excellence in Aesthetics

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Laser/IPL Medical History Questionnaire

Patient Name: ____ Date: ____/____/_____

1) Do you have ANY current or chronic medical illness we should know about?
If yes, please explain:
____

2) Do you use ANY topical medications/lotions/moisturizers/serums/retinoids on a regular/daily basis?
If yes, please name and indicate the last time you used them:
____
____

3) Do you have ANY allergies to medications/food/latex/cosmetics?
If yes, please list and explain:
____

4) Women: Are you pregnant or trying to become pregnant? ( ) Yes ( ) No

5) Women: Are your menstrual periods regular? ( ) Yes ( ) No

6) Do you have a history of herpes simplex or cold sores? ( )Yes ( ) No

7) Do you have a history of keloid scarring? ( ) Yes ( ) No

8) Have you taken or used Accutane, Retin-A, Hydroquinone, Benzoyl Peroxide, exfoliating agents, or anticoagulants in the last 6 months? ( ) Yes ( ) No

9) Have you had any Laser/IPL/Chemical Peel treatments in the past? ( ) Yes ( ) No
If yes, please list and explain:
____

10) What are your expectations for the outcome of the treatment?
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