SALUJA COSMETIC & LASER CENTER

Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **City:** _____ **St:** ____ **Zip:**_____

Email address:_____ **Primary Phone:** _____

Ok to send follow-up emails to this email address (circle one): **YES** **NO**

Interested in receiving practice promotions/specials (circle one): **YES** **NO**

Referral Source: _____

Primary Care Physician: _____

Dermatologist: _____**Date of Last Visit:** _____

Preferred Pharmacy:_____ **Location:**_____ **Phone:**_____

If you are a minor, who will be responsible for your account?

Name: _____ **Relationship to minor:** _____ **DOB:** _____ **DL #** _____

Telephone #: _____ **Address (*if different from above*):** _____

MEDICAL HISTORY:

Please check if you have or have had any of the following:

◯ Cold sores/Herpes ◯ Hepatitis ◯ Photosensitive Disorder ◯ Diabetes ◯ Sensitive to Anesthetic ◯ Lupus ◯ Hypertension

◯ Heart Problems ◯ Autoimmune Illness ◯ Irregular Menses ◯ Menopause ◯ Hysterectomy ◯ Hives ◯ Keliods

Past Surgical History (including Cosmetic): _____

Medications: _____

Allergies (circle one): YES or NO ***If yes, please list:*** _____

Have you ever used Retin-A? YES or NO ***If yes, what strength?*** _____

Have you ever used Hydroquinone (Skin Lightener)? YES or NO

Have you ever used Accutane? YES or NO ***If yes, when?*** _____

If you answer yes to the following please explain: _____

Skin Cancer: YES or NO **Use of Acne Products/Drugs: YES or NO** **Chemical Peels: YES or NO**

Hypersensitivity to Skin Products: YES or NO **Laser skin resurfacing: YES or NO** **Skin Infections: YES or NO**

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** ___/____/_____