Advanced Care For Women
ICON

MEDICAL HISTORY FORM **Skin Type: I II III IV V VI**

Last Name:_____ First Name:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Telephone - Home:_____ Cell:_____ Work:_____

Date of Birth:_____ Sex: Female:_____ Male:_____

Medications: none _____

Allergies: none_____

Which body area or condition do you want treated?_____

Please answer all of the following questions

1.	Do you have **any** chronic skin conditions including urticaria, diabetes, autoimmune disorders, immunosuppresion, cancer, or skin photosensitivity?	YES NO
2.	Do you have any chronic skin condition including vitiligo, eczema, melasma, psoriasis, allergic dermatitis, scleroderma, Ehlers-Danlos syndrome, or skin cancer?	YES NO
3.	Do you use any topical products on your skin on a regular basis?	YES NO
4.	Do you have a history of Herpes in the area to be treated?	YES NO
5.	Do you have a history of Keloid formation?	YES NO
6.	Do you have a history of light induced seizures?	YES NO
7.	Do you have any open sores in the area being treated?	YES NO
8.	Do you have any history of radiation therapy in the area being treated?	YES NO
9.	Have you had Botox or Dysport in the areas being treated?	YES NO
10.	Have you taken blood thinners or photosensitizing meds in the last 6 months?	YES NO
11.	Have you taken Retin-A or Renova in the last 6 months?	YES NO
12.	Have you taken Accutane in the last 12 months?	YES NO
13.	In the last 3 months have you used glycolic acid or alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments?	YES NO
14.	Have you had permanent make-up, tattoos, implants, or fillers such as collagen, autologous fat, Restalane, etc.?	YES NO
15.	Have you had any unprotected sun exposure, used tanning creams, sprays, tanning beds or lamps in the last 4 weeks?	YES NO

Signature:_____ Date:_____