Michael R. Macdonald, MD
BOARD CERTIFIED FACIAL PLASTIC SURGEON
Aesthetic Surgery & Skin Rejuvenation
500 Sutter Street, Suite 430
415.956.3223 San Francisco, CA 94102

Medical History
for Laser / BBL™ Skin Procedures

Name: _____

Address: _____

Phone #1: _____ **Phone #2:** _____

Female Male Age: _____ **Referred by:** _____

Reason for consultation

Acne
Brown spots or sun damage
Enlarged blood vessels
Flushing of the skin
Skin laxity
Fine lines or wrinkles
Skin texture or scars
Unwanted hair

Questions about skin

1. How long have you been concerned about this area(s)? _____
2. At what age did you notice this concern(s)? _____
3. Are your present skin concern(s) getting more pronounced? Yes No
4. Have you ever been treated for this concern(s)? Yes No
   If yes, when? _____
   What method? _____
5. Are you currently taking medication for your skin's concern(s)? Yes No
   If yes, what is it? _____
6. What topical skin medications or products are you currently taking?
   Retin-A® Hydroquinone or bleaching agent Other _____
7. Have you ever had laser / IPL hair removal? Yes No
8. Have you ever used the following hair removal methods in the past 6 weeks?
   shaving waxing electrolysis plucking/tweezing stringing depilatories
9. Have you ever had skin resurfacing or rejuvenation or chemical peels? Yes No

10. Have you ever had treatments for pigmented lesions? Yes No
11. Do you form thick or raised scars (keloids) from cut or burns? Yes No
12. Do you experience hyperpigmentation (redness) from burns, cuts, insect bites? Yes No
13. Have you had cold sores or fever blisters? Yes No

Skin Type choices (when exposed to the sun for about 1 hour with no protection):

- Always burns, never tans
- Always burns, sometimes tans
- Sometimes burns, always tans
- Rarely, burns, always tans
- Brown, moderately pigmented skin
- Black skin

1. When was your last exposure to the sun or tanning booth? _____
2. Do you use self tanners? Yes No
3. Are you planning a vacation in the sun? Yes No

Personal history:

1. Do you smoke? Yes No if yes _____ packs per day
2. What is your daily consumption of alcohol? _____
3. Do you wear contact lenses? Yes No

Medical history:

1. Are you currently under the care of a physician? Yes No. If yes, for what:
   _____
2. Do you have any of the following?

Arthritis	Bleeding disorders	Dark spots of pregnancy
Any active infection	Bruising	Diabetes
Epilepsy or seizures	Herpes simplex	
Heart disease	High blood pressure	
Hepatitis	Hormone imbalance	
HIV / Aids	Skin cancer or moles	Vision deficits
Sensitive teeth	Skin injury	Other_____

3. Do you have allergies to any of the following? (check all that apply) medications latex

   food plants anesthesia other_____

4. Do you take any of the following?

Accutane	Anti-coagulants
Antibiotics	Anti-depressants
Appetite depressants	Cortisone or steroids
Aspirin or Ibuprofen	Hormone/contraceptives
Insulin	Thyroid medication
Sedatives	Other____

5. Are you taking herbal preparations or vitamins? (St. John's Wort, Vitamin E) Yes No

_____

For female patients:

1. Are you pregnant or trying to become pregnant? Yes No

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Signature: _____ Date: _____