NEW PATIENT FORM

Patient Na	me:
Address: _	City: TX, Zip:
Home Ph:	
Date of bil	tii Sex. Male Female
Medical H	<u>listory</u>
Have you	ever had the following?
• Cu	urrent or history of cancer, if so what:
• Ar	ny active infection or broken skin, if so what?
• Di	iseases which may be stimulated by light such as a history of Herpes Simplex, Systemic Lupus
Er	rythematosus, or Porphyria 📮
• Us	se of photosensitive medication and or herbs that cause sensitivity to light exposure such as
Iso	otretinoin, tetracycline, or St Johns Wort.
• Im	nmunosuppressive diseases, including AIDS and HIV infection or use of immunosuppressive
me	edications. 🖵
• Hi	istory of hormonal or endocrine disorders such as polycystic ovary syndrome or diabetes.
• Hi	istory of bleeding coagulopathies, or use of anticoagulants \Box
• Hi	istory of keloid scarring 🖵
• Pa	cemaker/defibrillator □
• Ac	ecutane w/in last 6 mths \Box
• Fr	agile/intolerant skin □
Are you pr	regnant?
	ications are you taking?
	al preparations are you taking?
•	ear contact lenses?
	(when exposed to the sun without protection for about an hour?)
	ways burns, never tans \Box
	ways burns, sometimes tans \Box
	ometimes burns, sometimes tans
	ways tans 🗖
	spanic Asian Mediterranean Middle Eastern Indian Black Caucasian
	hen were you last exposed to the sun or artificial tanning?
Reason for	· visit:
Prior treatment, if any:	