# Mystic Medical Aesthetics LLC

107 Wilcox Rd. #106 Stonington, CT 06378

## CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment and/or laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth_____ Age_____Occupation_____

Home Address_____

City_____ State_____Zip Code_____

Home Phone (____) _____Work Phone (____)_____

Cell Phone (____)_____e-mail_____

Emergency Contact Name and Phone_____

How were you referred to us?_____

Do you regularly sunbathe or use tanning salons? _____Howoften?_____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? ▢ Yes ▢ No

If yes, for what:_____

Are you currently under the care of a dermatologist? ▢ Yes ▢ No

If yes, for what:_____

Do you have a history of erythema ab Igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation?

▢ Yes ▢ No

Do you have any of the following medical conditions? (Please check all that apply)

▢ Cancer ▢ Diabetes ▢ High blood pressure ▢ Herpes ▢ Arthritis
▢ Frequent cold sores ▢ HIV/AIDS ▢ Keloid scarring ▢ Skin disease/Skin lesions
▢ Seizure disorder ▢ Hepatitis ▢ Hormone imbalance ▢ Thyroid imbalance
▢ Blood clotting abnormalities ▢ Any active infection

Do you have any other health problems or medical conditions? _____

Please list:_____

Have you ever had an **allergic reaction**? (List any and all that you have had and describe the reaction you experienced) ▢ Food ▢ Animal Protein ▢ Aspirin ▢ Lidocaine ▢ Hydrocortisone ▢ Hydroquinone or skin bleaching agents ▢ Others (Please list):

_____

MEDICATIONS

What oral prescription medications are you presently taking?

▢ Birth control pills ▢ Hormones

Others (It is required that you list all of them):_____

_____

Have you ever used Accutane? ▢ Yes ▢ No, If yes, when did you last use it?_____

What antibiotics do you use to treat infections?_____

Do you take any medications for heart conditions?_____

Are you on any mood altering or anti-depression medication?_____

What topical medications or creams are you currently using? ▢ RetinA, ▢ Others (Please list):_____

What herbal supplements do you use regularly?_____

_____

HISTORY

Have you ever had laser hair removal? ▢ Yes ▢ No

Have you used any of the following hair removal methods in the past six weeks?

▢ Shaving ▢ Waxing ▢ Electrolysis ▢ Plucking ▢ Tweezing ▢ Stringing ▢ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin?

▢ Yes ▢ No

Have you recently used any self-tanning lotions or treatments? ▢ Yes ▢ No

Do you form thick or raised scars from cuts or burns? ▢ Yes ▢ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ▢ Yes ▢ No If yes, please describe:_____

For our female clients:

Are you pregnant or trying to become pregnant? ▢ Yes ▢ No

Are you breastfeeding? ▢ Yes ▢ No

Are you using contraception? ▢ Yes ▢ No

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date:_____