Padda institute

CENTER FOR LASER AND AESTHETIC MEDICINE

PATIENT MEDICAL HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Preferred Contact Number: _____

Emergency Contact Number:

Emergency Contact: _____ _____

E-Mail Address: _____ May we e-mail you? YES or NO

How did you hear about us? _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Work Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed

What treatment areas would you like to discuss with our physician/staff?

☐ Face & Jowls	☐ Neck (under chin)	☐ Upper Arms	☐ Upper Back (bra line)
☐ Sacral Area	☐ Flanks (love handles)	☐ Upper Abdomen	☐ Umbilicus
☐ Lower Abdomen	☐ Hips	☐ Outer Thighs	☐ Inner Thighs
☐ Knees	☐ Calves	☐ Ankles	☐ Female Breasts
☐ Male Chest (breasts)	☐ Buttocks/Banana Folds	☐ Lipoma	☐ Other: _____

I certify that the above medical history information is accurate and correct.

_____ _____

Patient Signature Date

Padda institute
CENTER FOR LASER AND AESTHETIC MEDICINE

PATIENT MEDICAL HISTORY *(CONTINUED)*

Check all services you are interested in

_____ Laser Hair Reduction
_____ Laser Vein Removal
_____ Micro Tuck
_____ Injectables
_____ Facials
_____ VelaSmooth
_____ Vibraderm
_____ ProFractional
_____ Pigmented Lesions or Brown Spot Removal
_____ 3D Liposculpture
_____ CHANGES
_____ Mesotherapy/LipoDissolve
_____ MicroLaser Peels
_____ Skin Tyte
_____ G-SHOT
_____ Other: _____

Do you have rosacea? YES or NO
Do you have wrinkle concerns? YES or NO
Do you have scarring concerns? YES or NO
Do you have sun damage concerns? YES or NO
Do you have pigmentation concerns? YES or NO
Do you have broken capillary concerns? YES or NO

Have you been on Accutane in the past 6 months? YES or NO

If yes, explain: _____

_____

Have you had any hernias, scars or prior surgery in the body area(s) you would like treated? YES or NO

If yes, explain providing date of surgery, surgery performed, etc.: _____

_____

Have you ever before had a Liposuction or LipoDissolve treatment or procedure? YES or NO

If yes, explain providing date of treatment, treatment description, area treated, etc.: _____

_____

I certify that the above medical history information is accurate and correct.

_____ _____

Patient Signature Date

Padda institute
CENTER FOR LASER AND AESTHETIC MEDICINE

PATIENT MEDICAL HISTORY *(CONTINUED)*

Have you ever had a blood clot? YES or NO

If yes, explain providing date, description, etc.: _____

_____

Current Prescribed Medications: _____ Prescribed By: _____

_____ Prescribed By: _____

_____ Prescribed By: _____

_____ Prescribed By: _____

Current Over-the-Counter Medications: _____

_____

_____

_____

Current Herbal Remedies: _____

_____

Do you take Aspirin, Ibuprofen or NSAID's? YES or NO If Yes, which one and how often? _____

Do you smoke or chew tobacco? YES or NO How much? _____ How many years? _____

Do you drink alcohol? YES or NO If Yes, how much and how often? _____

Do you exercise? YES or NO If Yes, what type and how often? _____

I certify that the above medical history information is accurate and correct.

_____ _____

Patient Signature Date

Padda institute
CENTER FOR LASER AND AESTHETIC MEDICINE

PATIENT MEDICAL HISTORY *(CONTINUED)*

Do you have any allergies, including but not limited to medications, substances, dairy, peanuts, soy, latex? YES or NO

If yes, explain providing allergy, description, etc.: _____

_____

Have you had any of the following? *(circle all that personally apply to you)*

Asthma	Arthritis	Anemia	Autoimmune Disorder	Anxiety
Chronic Diarrhea	Clotting Disorder	Colon Problems	Diabetes	Suicide Attempt
Heart Murmur	Easy Bruising	Excessive Scarring	Excessive Bleeding	Depression
Heart Attack	Heart Condition	Heart Valve Replacement	Heart Failure	Bulimia
High Blood Pressure	Hepatitis	HIV (AIDS)	Irregular Heart Beat	Anorexia
Intestinal Problems	Keloid Scars	Kidney Disease	Liver Disease	Drug Abuse
Lung Disease	Multiple Sclerosis	Muscular Dystrophy	Mitral Valve Prolapse	IV Drug Use
Cold Sores/Herpes	Permanent Make-Up	Tattoo	Pregnant	Miscarriages
Migraines	Rheumatic Fever	Shortness of Breath	Seizures	Stroke
Stomach Problems	Thyroid Disorder	Cancer (what kind):	Other: _____	

If yes, please explain: _____

_____

_____

I certify that the above medical history information is accurate and correct.

_____ _____

Patient Signature Date

Padda institute
CENTER FOR LASER AND AESTHETIC MEDICINE

PATIENT MEDICAL HISTORY *(CONTINUED)*

Acne

Do you have a history of breakouts? YES or NO

If so, what is the frequency of your breakouts? _____ Frequent _____ Occasional _____ Rarely

Do you experience cystic breakouts? YES or NO Do you have any scarring as a result of your acne? YES or NO

Skin Background

Have you had prolonged sun exposure or tanning bed usage in the past three (3) days? YES or NO

If yes, are you currently sunburned? YES or NO Do you use chemical tanning solutions? YES or NO

Do you use tanning beds? YES or NO If yes, how often? _____ Do you use sunscreen on a regular basis? YES or NO

Have you waxed, used depilatories, bleaches or other chemical processes? YES or NO

If yes, please explain providing the date last used, product, etc. _____

Have you ever had microdermabrasion? YES or NO

Have you ever had a chemical peel? YES or NO

Have you ever had laser resurfacing? YES or NO

Have you had Botox or Collagen injections in the past six (6) months? YES or NO

If yes, please explain providing date of treatment, injectable used, area treated, etc. _____

_____

Do you use topical ointments? _____ Retin-A _____ Glycolic _____ Lactic Acid _____ Hydroquinone

Other _____

What type of skin care products are you currently using? _____

I certify that the above medical history information is accurate and correct.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date