GALEN
LASER AESTHETICS
RENEW • REJUVENATE • MADE AFFORDABLE

Cosmetic Consultation and Medical Questionnaire

Today's Date: _____

Name: _____ Date of Birth: ____/____/_____

Age: _____ Sex: _____ Height: _____ Weight: _____

Home Telephone: ( ) _____ Cell Phone: ( ) _____ Business Telephone: ( ) _____

Home Address: _____ **E-Mail Address:** _____

City: _____ State: _____ Zip: _____

Occupation: _____ Marital Status (circle one): S M D W

Spouse's Name: _____

How would you like us to confirm your appointments? [ ] TEXT MESSAGE [ ] EMAIL

How did you hear about us?

□ Friend/Family _____
□ Search Engine (Google, Yahoo, MSN)
□ Social Media (Facebook/Twitter)
□ Organization_____
□ Gift Certificate
□ Walk In
□ Product Website: _____
□ Other _____

List All Cosmetic Procedures You Have Had (Botox, Lasers, Injectable Fillers, Peels)

Procedure	Year	Doctor/Spa	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

[ ] Yes [ ] No Were there complications? (*If yes, please explain*) _____
[ ] Yes [ ] No Did you have a normal recovery? (*If no, please explain*) _____
[ ] Yes [ ] No Were you satisfied with the results? (*If no, please explain*) _____

List Medical Conditions (Hypertension, Diabetes, Cancer)

_____ _____

_____ _____

List Surgeries, including cosmetic (breast augmentation, face lift, eyelid surgery, etc.)

_____ _____

_____ _____

Are you currently under the care of a physician for a medical / surgical / psychiatric problem?

Explain: _____

Who Is Your Doctor? _____

Medication:

[ ] Yes [ ] No Please list any **prescription** or **over-the-counter** medication regularly or occasionally taken (including aspirin, Advil, vitamins. etc)?

_____ _____ _____

_____ _____ _____

Allergies to Medication:

[ ] Yes [ ] No Are you allergic to any medication, aspirin, antibiotics, latex etc.? (*If yes, please list and explain reaction)*

_____ _____ _____

Other Allergies: (fruit, seafood, cosmetics)

_____ _____ _____

Women:

[ ] Yes [ ] No Do you have polycystic ovary disease?
[ ] Yes [ ] No Is there any possibility that you are pregnant?

Skin Care History

What is your ancestry? (**Irish, English, African, Latin, Indian, Asian, etc**.) _____

What is it about your skin you would like to improve? (Wrinkles, Age spots, Broken Capillaries, Acne) _____

_____

List the skin care products you currently use both over the counter and prescription:

_____ _____ _____

_____ _____ _____

[ ] Yes [ ] No Have you had an injury, to the face, nose, neck, or eyes? (*If yes, when?)*_____
[ ] Yes [ ] No Do you smoke? If yes, number of packs per day_____ for how long _____
[ ] Yes [ ] No Do you drink any alcoholic beverages? Number of drinks per day _____
[ ] Yes [ ] No **Have you ever had a cold sore, shingles, or herpes?**
[ ] Yes [ ] No Do you take aspirin or blood thinners?
[ ] Yes [ ] No Do you exercise regularly?
[ ] Yes [ ] No Have you had permanent cosmetics done?
[ ] Yes [ ] No Do you have tattoos?
[ ] Yes [ ] No Have you had a "reaction" to any anesthetic (Novocaine/Lidocaine) administered by a dentist or doctor?
[ ] Yes [ ] No Are you taking or have you taken Acutane? When?_____
[ ] Yes [ ] No Are you using a topical vitamin A? (Tretinoin, Retin A, Retinoic Acid, Tazorac, Differin, Renova, etc.)
[ ] Yes [ ] No Have you used a tanning bed or been sun bathing in the last week?
[ ] Yes [ ] No Are you using Glycolic Acid/Hydroxy Acid
[ ] Yes [ ] No Have you ever had an allergic reaction to any skin product or cosmetic?
Explain: _____

[ ] Yes [ ] No Are you on hormone replacement therapy?
[ ] Yes [ ] No Do you take birth control pills?
[ ] Yes [ ] No Do you have skin discoloration? (Melasma, light, brown, red, or dark areas)
[ ] Yes [ ] No Do you use sunscreen?
[ ] Yes [ ] No Are you currently under a physicians care for a skin care condition?
Explain: _____

Please answer the following:

[ ] Yes [ ] No I accept the fact that there are risks involved in every cosmetic procedure
[ ] Yes [ ] No I am aware that the possibility exists that my cosmetic treatments may not fully meet my expectations.
[ ] Yes [ ] No I understand that results of my cosmetic treatment are dependant upon full and complete disclosure of all medical and surgical information pertaining to me; and, that omission of issues relating to my health, past surgical history, current medications and allergies, or any other pertinent information may directly affect my personal safety and/or results; and I will follow my post care instructions.

Signed_____**Date**_____