Sierra Nevada Wellness Center

3160 Vista Blvd. Sparks, NV 89436

(775) 352-7200

Laser Treatment Medical History

Today's Date:_____ Date of Birth:_____

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone: HOME:_____WORK:_____CELL:_____

Email:_____

What is the best number to call you at? Circle HOME WORK CELL May we leave a message? Y / N

Emergency Contact and Phone# _____

Yes / No Do you have ANY current or chronic medical illnesses?

Please List :_____

Yes / No Do you have ANY allergies to medications, foods, latex or other substances?

Please List :_____

Yes / No Do you take /use ANY medications, both prescription and non-prescription, herbal or natural supplements, or topicals on a regular or daily basis? List:_____

Please Circle Yes or No

Yes / No Do you have a history of “cold sores” or herpes I or II in the area to be treated?

Yes / No Do you have a history of diabetes or problems with wound healing?

Yes/ No Do you have cancer, heart conditions, seizure disorder, hepatitis, HIV/AIDS, or thyroid imbalance?

Yes / No Do you have a history of keloid or hypertrophic scarring or abnormal scarring?

Yes / No Do you have any active infections or compromised ability to healing?

Yes / No Do you take St. John’s Wort or any anticoagulants?

Yes / No Do you have any permanent make-up, implants or tattoos?

Yes / No Do you have any open lesions in the area to be treated?

Yes / No Have you taken Accutane in the last 6 months?

Yes / No Have you used any exfoliating creams or products (Retin A, Differin, Glycolic acid,

Alphahydroxy acid products) in the last two weeks?

Yes / No Have you had any unprotected sun exposure, used self-tanning creams or tanning?

beds in the last 4-6weeks to the area to be treated?

Yes / No Have you had any cosmetic injections (ie: Botox or fillers) in the last 6 months?

Yes / No For women: Are you or could you be pregnant?

Yes/ No Do you have any known hormone imbalance?

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

Yes/No Have you every had laser hair removal?

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

□Shaving □Waxing □Electrolysis □Plucking □Tweezing □Stringing □Depilatories

Yes/No Are you prone to hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical

trauma to the skin? If yes, describe_____

Whick of the following best describes your skin type when exposed to direct sunlight without protection for approximately one hour?

1. Always burns, never tans
2. Usually burns, tans with difficulty
3. Sometimes burns, usually tans
4. Rarely burns, tans easily (i.e. Native American)
5. Very rarely burns, olive tone skin (i.e. Hispanic, Indian)
6. Never burns, dark pigmented skin (i.e. African American)

I certify that the supplied medical and personal history statements are true and correct. I am aware that it is my repsonsibility to inform the technician or doctor of my current medical or health conditions and to update this history. A current and correct medical history is essential for the caregiver to supply appropriate treatment procedures. I also understand that is my repsonsibility to keep scheduled appointments and to call 24 hours in advance if unable to keep appointments. If I fail to cancel in advance, a $25 no show fee may be assessed.

_____ _____

Signature Date