Laser Service Consult form

Name: ____ Date: ____________

Have you ever had the following?

- Current or history of cancer, especially malignant melanoma or recurrent skin cancer or pre-cancerous lesions
- Any active infection, especially Herpes Simplex in the treatment area
- Diseases which may be stimulated by light, such as a history of Herpes Simplex (cold sores), Systemic Lupus, Seizure disorders, or Porphyria
- Use of Accutane (Isotretinoin) in the previous year
- Immunosuppressive diseases, including AIDS, and HIV infection, or use of immunosuppressive medications
- History of hormonal or endocrine disorders (ie insulin dependent diabetes, PCOS)
- History of bleeding disorders, or use of blood thinners
- History of keloid scarring
- Very dry skin
- Exposure to sun or artificial tanning during the past 3-4 weeks
- Pregnant YES / NO
- All medications (including aspirin and topical/skin medication)
  ____
- Allergies ____
- Herbal supplements (St. John's Wart, etc)
  ____
- Do you wear contact lenses? YES / NO

How does your skin respond to the sun without protection for about an hour?

- Always burns, never tans
- Always burns, sometimes tans
- Sometimes burns, sometimes tans
- Always tans
- Hispanic Asian Mediterranean Middle Eastern Black (circle if applicable)

When were you last exposed to the sun (including tanning booth)?____________________________

Do you use self-tanning lotions or sprays? YES / NO Last date used? _________________________

Prior treatment (if any) ____

Signature of patient____ Date______________________