Medical Laser & Skin Rejuvenation Center
2163 Oak Tree Rd, Suite 103, Edison, New Jersey 08820
Phone: 732-485-0840

PATIENT MEDICAL INFORMATION

NOTE: The dermatologic examination you are about to receive is not a complete physical examination. It is suggested that you have annual physical examinations by your family physician or internist.

PLEASE PRINT AND COMPLETE ALL INFORMATION Date: ___________________________

Patient Last Name: ________________ First, MI: ___________________ Age: ______ Sex: M F
Address: ____ Email: ______________
Home Phone: ________________ Cell Phone: ________________ Work Phone: ____________
Date of Birth ________________ SSN: ________________ Marital Status M S W D
Employer: ________________ Address ________________ Occupation: ____________
Emergency Contact: ____________ Relationship: ____________ Phone: ______________
Referred By: ☐ Family ☐ Phonebook ☐ Friend ____________ ☐ Other: ______________

Allergies ☐ No ☐ Yes: ____

When you go into the sun without a tan, you:

☐ Always burn, never tan ☐ Usually burn, sometimes tan
☐ Sometimes burn, usually tan ☐ Never burn, always tan

Have you ever had a skin problem or been under the care of a dermatologist? ☐ No ☐ Yes:

____

Have you had any facial procedures in the past year? ☐ No ☐ Yes:

____

Have you ever been given an X-ray or Grenz treatments to your skin? ☐ No ☐ Yes: ____________

Prior hospitalization and surgery: ____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	# times a day	Drug Name	Dose	#times a day

Have you ever had or currently having the following conditions?

☐ Photosensitive reactions (e.g. lupus)	☐ Thrombophlebitis	☐ Took Accutane in last year
☐ Allergy to local anesthetics or Anaphylaxis	☐ Cancer (e.g. skin)	☐ Had gold therapy
☐ Liver or gall bladder disease	☐ Ulcer/intestinal disease	☐ Took isotretinoin in last 6 mon
☐ Lung disease (e.g. TB, pleurisy, asthma)	☐ High blood pressure	☐ Took anticoagulants
☐ Heart disease (e.g. heart attack, arrhythmia)	☐ Overgrown scars/keloids	☐ Seizure triggered by light
☐ Endocrine/Hormonal disease	☐ Eczema	☐ Have suspicious pigmented lesions
☐ Emotional or psychiatric problem	☐ Psoriasis	☐ Unprotected sun exposure last 4 wk
☐ Neurological disorder/Stroke	☐ Had blood transfusion	☐ Tanning booth last 4 weeks
☐ Urinary or bladder problem/infection	☐ Diabetes	☐ Poor wound healing
☐ Excessive bleeding when cut	☐ Kidney disease	☐ Immunosuppression
☐ Blood disorder or lymph gland disorder	☐ Venereal disease	**Women Only:**
☐ Eye disease (e.g. glaucoma, cataract)	☐ HIV/AIDS	☐ Vaginal yeast infection
☐ Arthritis, joint problem, or bone disease	☐ Hepatitis B/hepatitis C	☐ Are you pregnant?
☐ Frequent infection (Skin or other)	☐ Cold sores	☐ Are you planning a pregnancy?

Please explain: ____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report to your office as soon as possible. I acknowledge that all answers have been recorded truthfully and I will not hold anyone else responsible for any errors or omissions that I have made in the completion of this form.

Sign: ____________________ Date: __________ Reviewed by: ____________ Date: ___________