DR. SUSAN TAN

CLIENT HISTORY FORM

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____ City_____ State___Zip Code_____

Home Phone (___)_____Work Phone (____)_____

Emergency Contact Name and Phone_____

Email Address _____

How were you referred to us? _____

MEDICAL HISTORY

Are you currently under the care of a physician? _____Yes _____No

If yes, for what:_____

_____

Do you have any of the following medical conditions? (Please check all that apply)

_Cancer _Diabetes _High blood pressure _Herpes _Arthritis

_Frequent cold sores _HIV/AIDS _Keloid scarring _Skin disease/Skin lesions

_Seizure disorder _Hepatitis _Hormone imbalance _Thyroid imbalance

_Blood clotting abnormalities _Any active infection _Do you smoke?

_Thyroid disease _Circulatory problems _Tumors/Growths

Do you have any other health problems or medical conditions? Please list: _____

_____

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Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) _Food _Animal Protein _Aspirin _Lidocaine _Hydrocortisone _Hydroquinone or skin bleaching agents _Others:

_____

MEDICATIONS

What oral prescription medications are you presently taking? _Birth control pills _Hormones _Steroids _Others (It is required that you list all of them): _____

_____

Surgical History. Please list all surgeries. _____

_____

IPL/Laser History. Please list all treatments. _____

_____

Liposuction History. Please list. _____

_____

Have you had complication or bad reactions to anesthesia? _Yes _No

_____

Are you on any mood altering or anti-depression medication?_____

What topical medications or creams are you currently using? _ RetinA , _Others (Please list):

_____

What herbal supplements do you use regularly?_____

Have you ever had an allergic reaction to the following? _ Latex _Lidocaine _Anesthesia _Topical Anesthesia _Others

GENERAL QUESTIONS

When did you last tan your skin? _____

When were you last exposed to sun, tanning beds, creams? _____

Have you had any of the following injections or fillers? _Collagen _Botox _Dermal Filler _Other

Date of last treatment. _____

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Do you have any problems with hypopigmentation or hyperpigmentation? _Yes _No

Have you ever had sclerotherapy? _____

When a scar appears on your skin, is it significantly dark in color? _____

SKIN TYPE

Ethnicity: _White _Asian _Hispanic _Mediterranean _Middle Easter _Black _Combination

Which of the following best describes your skin reaction when you are in the sun?

_Type 1: always burns, never tans. Red hair, blonde hair, light eyes.

_Type 2: somewhat tans, mostly burns.

_Type 3: sometimes burns, mostly tans, also known as olive complexion.

_Type 4: rarely burns, almost always tans, also known as olive complexion.

_Type 5: moderately pigmented (Indian, Persian, light African-American.

_Type 6: African-American

Do you wear sunscreen? _Never _Sometimes _Always

Skin Care Regimen: Please specify products you are currently using:

_____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? _Yes _No

Are you breastfeeding? _Yes _No

Are you using contraception? _Yes _No

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I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

_____

Client Name (Print) Client Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

_____

Doctor Name (Print) Doctor Signature Date