

# LASER TREATMENT CENTER

www.kirklandlaser.com

## MEDICAL INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Date \_\_\_\_\_ Reason for Visit \_\_\_\_\_

Were you sent here by your doctor?  Y or  N Physician that sent you \_\_\_\_\_

**List all medications you are currently taking:** \_\_\_\_\_

Are you allergic to any medications?  Y  N List: \_\_\_\_\_

**Social History/Habits:**  In school  Single  Married Occupation: \_\_\_\_\_

Use/Smoke Tobacco  Y  N Drink Alcohol?  Y  N If yes  Occasional  3 or more per week  Daily

### Past Medical History & Review of Systems

Check the following conditions that have occurred in you or your family

### Family History

You Mother Father Brother/  
Sister

(Explain all checked items)

#### Skin Disease in Your Family

Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer – Unknown Type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Basal Cell or Squamous Cell Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other skin problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

#### Your Overall Health:

Cancer other than skin cancer	<input type="checkbox"/>	_____
Eyes / Ears / Nose / Throat / Mouth disease	<input type="checkbox"/>	_____
Allergies / Hay Fever	<input type="checkbox"/>	_____
Lung disease / Asthma / COPD	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	_____
Blood / Bleeding Disorder	<input type="checkbox"/>	_____
Heart disease, pacemaker, or defibrillator	<input type="checkbox"/>	_____
Unusual headaches / seizure / stroke	<input type="checkbox"/>	_____
Psychological disorder / depression	<input type="checkbox"/>	_____
Thyroid disease / diabetes	<input type="checkbox"/>	_____
Liver disease / hepatitis	<input type="checkbox"/>	_____
Stomach / bowel disease	<input type="checkbox"/>	_____
Kidney / bladder problem	<input type="checkbox"/>	_____
Arthritis / muscle / joint disease	<input type="checkbox"/>	_____
Autoimmune disease	<input type="checkbox"/>	_____
Other medical problem	<input type="checkbox"/>	_____

Response to sun exposure:  Always burn  Burn easily  Some tan, some burn  Tan easily, rarely burn  Never burn

Use of indoor tanning beds:  Never  Rarely in past  Before travel or events  Several times each month

**Females:** Are you pregnant/Nursing?  \_\_\_\_\_