Jeri Shuster, M.D., P.A.
and Women's Center, Inc.

MEDICAL LASER & SKIN SERVICES

Patient:_____Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Address:_____

Phone:_____ Cell Phone: _____

Email:_____@_____Please circle preferred method of contact

Emergency Contact Name & Number:_____

How did you hear about our Aesthetic Office?_____

Reason for Consultation: _____

Are you currently under a physician's care? ( ) YES ( ) NO If yes, please list:_____

List all medications your are currently taking (include prescriptions, over-the-counter meds, vitamins, & herbs):

_____

_____

Do any of your medications prohibit exposure to sun or light (cause photosensitivity)? ( ) YES ( )NO

Have you been on Accutane in the past 6 months? ( ) YES ( )NO

Have you undergone chemotherapy or radiation? ( ) YES ( )NO

Do you experience herpes or cold sore breakouts? ( ) YES ( )NO

Do you take aspirin, ibuprofen, vitamin E, or other blood-thinning medication? ( ) YES ( )NO

If YES, how recently?_____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
High Blood Pressure	( )	( )	Diabetes	( )	( )
Circulatory Problems	( )	( )	Thyroid Disorder	( )	( )
Heart Murmur/MVP	( )	( )	Prostate Disease	( )	( )
Irregular Heartbeat	( )	( )	Chronic Headaches	( )	( )
Phlebitis	( )	( )	Convulsions, Epilepsy, Seizures	( )	( )
Inflammation of Veins	( )	( )	Fainting/Dizziness	( )	( )
Blood Clots	( )	( )	HIV/AIDS	( )	( )
Pacemaker	( )	( )	Hormonal Condition	( )	( )
Peripheral Vascular Disorder	( )	( )	Hepatitis (any type)	( )	( )
Anxiety/Depression	( )	( )	Visual Disturbances	( )	( )

Other Diseases or Conditions:_____ **Women:**

_____ Polycystic Ovarian Syndrome ( ) ( )

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List all surgical procedures & dates : _____ Menstrual Irregularity ( ) YES ( ) NO

_____ Pregnant? ( ) YES ( ) NO

Do you get redness/darkness from scars: ( ) YES ( ) NO

Have you had skin cancer? ( ) YES ( ) NO

If yes, what type?_____ When?_____

Do you wear sunscreen daily? ( ) YES ( ) NO

SPF #_____ How often do you reapply SPF?_____

When were you most recently in the sun?_____Activity?_____Duration of exposure:_____

Do you have any specific skin diseases? ( ) YES ( ) NO

Which?_____

Do you have problems with healing? ( ) YES ( ) NO

Have you had blistering sunburns? ( ) YES ( ) NO

When?_____

Do you develop keloids (raised bumpy scars)? ( ) YES ( ) NO

Do you bleed easily? ( ) YES ( ) NO

Do you smoke? ( ) YES ( ) NO

Do you have any tattoos or permanent makeup? ( ) YES ( ) NO

Where?_____

Do you develop skin rashes in reaction to : ( ) Medications ( ) Food ( ) Topical Neosporin

( ) Environment ( ) Latex ( ) Bandages ( ) Anesthetics (Novocaine, xylocaine, lidocaine, etc.)

( ) Other _____

SKIN CONCERNS (Please circle the Conditions that Apply to You):

Excessive/Unwanted Hair Acne Flushing/Blushing Roseacea Enlarged Pores Oily/Dry Skin

Fine Lines Broken Capillaries Age/Sun Spots Scarring Black/Whiteheads Rough/dull Tone & Texture

Red Spots on Body Sagging Skin Loss of Facial Volume/Fullness Thin Lips Drooping Sparse/short eyelashes

Other:_____

SKIN REGIMEN (Please Circle Which Products You Currently Use and Specify the Type/Brand:

*Cleanser: Foaming Liquid Gentle/Milk/Non-foaming Type/Brand:_____

Glycolic Grainy _____

Bar Acne-specific _____

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*Toner: Moisturizing Clarifying Type/Brand:_____

Acne-specific Balancing _____

*Moisturizer: Oil-free Anti-Aging Type/Brand:_____

Cream Glycolic _____

*Treatment Products:_____

*SPF # _____ Type/Brand:_____

Prescription products (such as Retin-A, Triluma, Hydroquinone):_____

SKIN PROCEDURE HISTORY:

Have you undergone any of the following procedures?

	YES	NO	WHEN?
Microdermabrasion (Professional or At-Home)	( )	( )	_____
Chemical Peel (Professional or At-Home)	( )	( )	_____
Laser Resurfacing	( )	( )	_____
Laser Hair Reduction	( )	( )	_____
Botox	( )	( )	_____
Injectable Filler	( )	( )	_____
Thermage	( )	( )	_____
Fraxel	( )	( )	_____
Sclerotherapy	( )	( )	_____
IPL/Photofacial	( )	( )	_____
Facial	( )	( )	_____
Waxing/Threading/Depilatories	( )	( )	_____

Please disclose any minimally invasive cosmetic surgical procedures you have had:

What type:_____

When: _____

Please disclose any cosmetic surgical procedures that required general anesthesia:

What type:_____

When: _____

Please list any additional concerns or questions you have regarding your skin and aesthetic issues: _____

_____

_____

Thank you for taking your time to answer all of the above questions. We appreciate you providing all of your personal medical information in order to give you a proper and accurate assessment of your skin's aesthetic needs.

_____ _____/_____/_____

PATIENT SIGNATURE **DATE**

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