Bellevue Laser Cosmetic Center

MEDICAL INTAKE QUESTIONNAIRE

Name: _____ DOB:__/__/____

Phone #: _____
OK to leave message on this number? Yes No

Email: _____
Please send e-mails for events/promos Yes No

Referred by: _____

Primary Care Doctor: _____

Pharmacy: _____

Do you have any of the following:

	Yes	No
Cardiac pacemaker or defibrillator:	☐	☐
Take antibiotics for dentist:	☐	☐
On blood thinners:	☐	☐
Artificial joint or heart valves:	☐	☐
HIV/AIDS:	☐	☐
Hepatitis B or C:	☐	☐
History of severe bleeding:	☐	☐

Personal medical History:

	Self	Family
Cancer (type): _____	☐	☐
Thyroid:	☐	☐
High blood pressure:	☐	☐
Diabetes:	☐	☐
Heart disease/Heart attack:	☐	☐
Blood vessel disorder:	☐	☐
Blood clots:	☐	☐
Asthma:	☐	☐

Other medical problems:

_____
_____

Current medications:

_____
_____

Medication allergies:

_____
_____

Skin history:

Personal history of skin cancer: Yes No

If yes, circle what type:
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

Family history of skin cancer: Yes No

If yes, circle what type:
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

MISC:	Yes	No
Difficulty with wound healing:	☐	☐
Keloids or abnormal scarring:	☐	☐
Blistering sunburns:	☐	☐
History of tanning bed use:	☐	☐
Current tanning bed use:	☐	☐
Eczema:	☐	☐
Psoriasis:	☐	☐
History of radiation exposure:	☐	☐
Do you wear sunscreen?	☐	☐
Accutane in the past 12 months:	☐	☐

Social history:

Marital status:

Single Married Divorced Domestic partner

Separated Widowed

Occupation: _____

Tobacco use:

Smoking ☐ Chewing Tobacco ☐
Daily amount: _____ Years :_____

Alcohol use:

Yes ☐ No ☐ Occasional ☐
Amount: _____ How often? _____

Female: Nursing or pregnant