GOOD TO GREAT

Medical Aesthetic Solutions

Bruce J. Sand, M.D., F.A.C.S. Mary T. Sand, R.N., B.S.N., CNOR, PHN

MEDICAL HISTORY

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____

Telephone Numbers: Home: _____ Work: _____

Cell: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Referred by: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

	YES	NO
1. Do you have **ANY** current or chronic medical illness we should know about? If so, please list: _____ _____ _____	☐	☐
2. Are you currently under a doctor's care? If so, for what reason? Please list: _____ _____ _____	☐	☐
3. Do you take/use **ANY** medications, herbal/natural supplements or topicals on a regular or daily basis? If so, please list: _____ _____ _____	☐	☐
4. Do you have **ANY** allergies to medications, foods, latex or other substances? If so, please list: _____ _____ _____	☐	☐

	YES	NO
5. Are you on **ANY** cardiac medications and/or have a cardiac condition? If so, please list: _____ _____ _____	☐	☐
6. (For women) Are you or could you be pregnant?	☐	☐
7. (For women) Are your menstrual periods regular?	☐	☐
8. Do you have a history of Herpes I or II?	☐	☐
9. Do you have a history of keloid scarring?	☐	☐
10. Have you taken Accutane or anticoagulants in the last 6 months?	☐	☐

11. To determine skin type, check one of the following:

SKIN TYPE	COLOR	REACTION TO FIRST YEARLY SUN EXPOSURE WITHOUT SUNSCREEN
I	White	Always burn, never tan
II	White	Usually burn, tan with difficulty
III	White/Asian	Sometimes mild burn, average tan
IV	Moderate Brown	Rarely burn, tan with ease
V	Dark Brown	Very rarely burn, tan very easily
VI	Black	Never burn

12. What color is the hair you wish to remove? _____

13. Please describe its growth:
- Dense and coarse: ☐
- Medium growth: ☐
- Sparse and fine: ☐

14. Which body area/areas would you like treated? _____
_____
_____

Signature: _____ Date: _____