SALUJA COSMETIC & LASER CENTER

Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **City:** _____ **ST:** ___ **Zip:**

Email address:_____ **Primary Telephone:** _____

Who may we thank for referring you? _____

PERSONAL DATA: Primary Care Physician: _____

PHARMACY NAME_____ **LOCATION**_____ **PHONE NUMBER**_____

If you are a minor, who will be responsible for your account?

Name: _____ **Relationship to minor:** _____ **DOB:** _____ **DL #** _____

Telephone #: _____ **Address (*if different from above*):** _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

◯ Cold sores/Herpes ◯ Hepatitis ◯ Photosensitive Disorder ◯ Diabetes ◯ Sensitive to Anesthetic ◯ Lupus ◯ Hypertension

◯ Heart Problems ◯ Autoimmune Illness ◯ Irregular Menses ◯ Menopause ◯ Hysterectomy ◯ Hives ◯ Keloids

PAST SURGICAL HISTORY: _____

MEDICATIONS: _____

ALLERGIES: YES OR NO ***if yes, please explain***

COSMETIC SURGERY: _____

PLEASE CIRCLE YES OR NO: SMOKER? YES or NO Do you Suntan? YES or NO Use Sunscreen? YES or N0 Currently Pregnant? YES or NO

Please circle yes or no to the following questions:

Have you ever used Retin-A? Yes or No If yes, what strength?

Have you ever used Hydroquinone (Skin Lightener)? Yes or No

Have you ever used Accutane? Yes or No If yes, when?

If you answer yes to the following, please explain

Skin Cancer Yes or No Use of Acne Products/Drugs Yes or No Chemical Peels Yes or No

Hypersensitivity to Skin Products Yes or No Laser skin resurfacing Yes or No Skin Infections Yes or No

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** ___/____/_____

(IF PRESCRIPTION IS WRITTEN TODAY A $25 FEE WILL BE COLLECTED)