

LASER & SKIN SURGERY CENTER OF NORTHERN CALIFORNIA

Laser & Skin Surgery Medical Group, Inc.

3835 J Street

Sacramento, CA 95816

(916) 456-0400

Patient Name _____ Age _____ Male Female

Allergies to Medications _____

Current Medications (please include vitamins, and birth control pills) _____

Reason for today's visit _____

Do you faint when given a shot? YES NO Do you form large scars (keloids) when injured? YES NO

Are you pregnant? YES NO

Have you ever had or been treated for any of the following? (✓ all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Keloids/Overgrown Scars |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Family History of Skin Cancers or melanoma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Grenz Ray Treatment or Radiation | <input type="checkbox"/> Skin Cancers |
| <input type="checkbox"/> Difficulty Healing of Wounds | <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Duodenal or Peptic Ulcers | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis or Lung Disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Vitiligo |

(If applicable, please list areas treated) _____

List any other past major surgeries or accidents. _____

Please indicate the services that interest you. (✓ all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne Treatment | <input type="checkbox"/> Full skin exam | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Laser hair removal | <input type="checkbox"/> Mole evaluation |
| <input type="checkbox"/> Blood vessel treatment | <input type="checkbox"/> Laser resurfacing | <input type="checkbox"/> Skin Cancer Surgery |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Laser surgery | <input type="checkbox"/> Skin rejuvenation for aging skin |
| <input type="checkbox"/> Fillers | <input type="checkbox"/> Leg vein treatment/sclerotherapy | <input type="checkbox"/> Treatment for scars and wrinkles |
| <input type="checkbox"/> Facials and Skin care products | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Other |

SIGNATURE _____ DATE: ____ / ____ / ____