LENOX LASER & ESTHETICS New York

Patient: _____ Date of Birth: _____

LIST OF ALL **ALLERGIES** TO MEDICATIONS OR SUBSTANCES: _____
_____

LIST OF ALL **MEDICATIONS**, VITAMINS, OTC PREPARATIONS OR RECREATIONAL DRUGS YOU ARE CURRENTLY TAKING:_____
_____
_____

LIST ANY ARTIFICAL IMPLANTS, **PACEMAKER**, ECT: _____

IF YOU **REQUIRE ANTIBIOTICS** PRIOR TO ANY PROCEDURES, PLEASE EXPLAIN: _____
_____

PERSONAL/CURRENT/PAST HEALTH PROBLEMS

Cancer	NO	YES _____	Eyes	NO	YES _____
Ears/Nose/Throat	NO	YES _____	Heart	NO	YES _____
High blood pressure	NO	YES _____	Liver Disease	NO	YES _____
Lungs	NO	YES _____	Stomach/bowel	NO	YES _____
Arthritis/joints	NO	YES _____	Kidneys	NO	YES _____
Headaches/seizures	NO	YES _____	Allergic/Immunologic	NO	YES _____
Psychological	NO	YES _____	Blood/Bleeding Disorders	NO	YES _____
Venereal disease	NO	YES _____	Other (diabetes,lupus,ect.)	NO	YES _____

MEDICAL HISTORY

	SELF	MOTHER	FATHER	BLOOD RELATIVE	EXPLAIN
Allergies	___	_____	_____	_____	_____
Asthma	___	_____	_____	_____	_____
Diabetes	___	_____	_____	_____	_____
Eczema	___	_____	_____	_____	_____
Skin cancer	___	_____	_____	_____	_____
Other	___	_____	_____	_____	_____

TO BE COMPLETED BY ALL WOMEN

Are you nursing or pregnant?	NO	YES
Are you currently planning a pregnancy?	NO	YES
Are you taking birth control pills?	NO	YES

PLEASE INFORM YOUR PHYSCIAN/NP AT ANY TIME IF YOU BECOME PREGNANT DURING YOUR TREATMENT

Patient or Parent/Guardian signature: _____ Date: _____