ROCKY MOUNTAIN LASER AESTHETICS

Patient Health History Form

In order for us to obtain a comprehensive medical history, it is important for you to fill out this form completely.

Full Name_____ **Date of Birth** _____

Reason for Visit _____ **Today's Date** _____

CURRENT MEDICATIONS

Are you taking ANY kind of medication now? (This includes prescription, over the counter, or herbal medications)

YES ☐ **NO** ☐

Medication Name	Dosage	How often taken

MEDICATION ALLERGIES: Are you allergic to any medications? YES ☐ NO ☐

Name of Medication	Type of Reaction

NON-MEDICATION ALLERGIES:

Are you allergic to anything in the environment such as pollens, dust, food, etc.? **YES** ☐ **NO** ☐

If yes, please indicate what you are allergic to: _____

Past Health History:

Have you ever been diagnosed with any major medical problem? **YES** ☐ **NO** ☐

If yes, please list below.

Medical Condition	Year Diagnosed

Have you had any previous surgeries? YES ☐ **NO** ☐

If yes please list below.

Type of Surgery	Date of Surgery