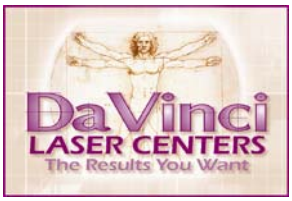

Phone: 817-614-3677 Fax: 817-288-0550
www.davincilasercenter.com

Patient Name: _____ **Date** ____/____/____

INFORMATION: (please complete this section in its entirety)

Reason for visit? _____

When did this start? When was condition first noticed? _____

Are you allergic to any medications? (please circle one) YES NO

If you circled YES, please list medications to which you are allergic:

_____

All medications you are currently taking: _____

_____

Any and all operations you have had: _____

_____

Are you currently scheduled for any upcoming surgeries? (please circle one) YES NO

If you circled YES, please list the surgery and expected date of operation:

_____

MEDICAL HISTORY: (please circle each condition or disorder that applies to you)

Acne	Glaucoma	Malignant Melanoma
Anemia	Hair Loss	Mitral Valve Prolapse
Arthritis	Hay Fever	Neurological Problems
Asthma	Headaches (chronic)	Psoriasis
Bleeding (excessive)	Heart Problems	Rheumatic Fever
Blood Clots	Hepatitis	Pacemaker
Breathing Disorder	Herpes Simplex (cold sores)	Scarring/Keloids
Bruise Easily	Herpes Zoster (shingles)	Skin Cancer
Cancer	High Blood Pressure	STD/Venereal Diseases
Cataracts	HIV	Stroke
Colon/Intestinal Disorders	Hives	Thyroid Disease
Convulsions/Seizures	Infections (chronic)	Tuberculosis
Depression	Kidney Disease	Ulcers
Diabetes	Liver Disease	Varicose Veins
Eczema	Loss of Skin Pigment	Vitiligo
Epilepsy	Lung Disease	Warts
Fainting Spells	Lupus	Wound Healing Difficult

Other Conditions: (please list/explain) _____

_____