

ADVANCED PLASTIC SURGERY

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IPL/Laser History and Physical

Name: _____ DOB: _____

Ethnicity: _____

What treatment(s) are you interested in (hair removal, vein treatment, photofacial, rosacea treatment, acne treatment)?: _____

On what area(s) of your body? _____

Please describe any problems you have had with any of the following:

Allergies _____

Unprotected sun exposure, use of tanning beds, use of self-tanners in areas to be treated

Menstrual dysfunction (hyperandrogenism, hirsutism, etc.) _____

History of keloid and hypertrophic scar formation _____

Active infections, open lesions, Herpes I or II within the treatment area _____

Diabetes _____

Heat urticaria _____

Risk of Paradoxical Hair Growth _____

Hair removal clients only: Use of mechanical epilation less than six weeks prior to treatment (plucking, waxing, tweezing, electrolysis, etc.) _____

History of seizures _____

Current pregnancy _____

Treatment of skin cancer _____

If you are taking any of the following medications, please circle them.

St. John's Wort

Tetracycline

Accutane

anticoagulants

Retin-A

herbal and natural medications

Plan: (for physician use only)

