Email Form | Print Form

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

Your honest replies to the questions within this questionnaire will assist Dr. Saya in developing a comprehensive and appropriate treatment plan for you. All answers and information contained in this questionnaire will be kept confidential.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Age:	**Height:**	**Weight:**
Address:	**City:** **State:**	**Zip:**
Email address:	**Phone Number:**	Cell or Home?
Primary Care or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Please describe your goals, area(s) of concern, and issues that you would like addressed:

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Please List ALL current or past hormone replacement or testosterone therapy medically supervised or otherwise			
Name the Drug	Date Prescribed	Strength	Frequency Taken

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

Defy MEDICAL
Your Concierge Medical Clinic

Consent for Laser Hair Removal

I understand that there are possible risks involved with laser hair removal, including but not limited to blistering, scarring, burning, hypopigmentation (lightening of the skin) and/or hyperpigmentation (darkening of the skin).
I understand that several sessions are necessary to receive the best results. Individual response will vary according to skin type, hair color, degree of tanning, follow up care and the body area being treated. Unprotected sun exposure in the weeks following treatment may worsen any of the above conditions. I understand I must update my medical history with any prescription medication changes as some medications may increase sensitivity to laser treatments. I understand results are not guaranteed.
I understand I am receiving treatment from Perfectly Bare under the care and medical license of Dr. Justin Saya, Medical Director of Defy Medical. By signing this consent, I authorize Defy Medical to maintain my demographic information and basic health questionnaire on file related to my treatment(s) with Perfectly Bare.

Please answer the questions below:

Have you used any of the following hair removal methods in the past 6 weeks?
[ ] shaving [ ] waxing [ ] electrolysis [ ] tweezing [ ] threading [ ] depilatories

Have you had exposure to the sun in the past 2-4 weeks (including self-tanning products)? YES NO

Have you used Retin-A, glycolic acid, bleaching products or a topical prescription product within the last 3-4 days? YES NO

Do you have a history of HSV (herpes, cold sores, fever blisters)? YES NO

Female patients- Are you currently pregnant? YES NO

Patient Signature: ____

Date: _________________