



**SOUTH COAST UROGYNECOLOGY**  
**Laguna Institute for Aesthetic Vaginal Surgery**

**AESTHETIC LASER/IPL HISTORY**

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Phone (Cell) \_\_\_\_\_ Email \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**CHIEF COMPLAINT** (Why you want to see the doctor today?)  
\_\_\_\_\_  
\_\_\_\_\_

**Which body area/areas or condition would you like treated?** \_\_\_\_\_

**PAST MEDICAL HISTORY/REVIEW OF SYSTEMS** (other current health problems):

Are you under a doctor's care? Yes No \_\_\_\_\_

Describe \_\_\_\_\_

Do you now have or have you ever had:

Neurologic (seizures, headaches, weakness, paralysis) problems? Yes No \_\_\_\_\_

Psychiatric problems? Yes No \_\_\_\_\_

Depression? Yes No \_\_\_\_\_

Head/Ear/Eyes/Nose/Throat Problems? Yes No \_\_\_\_\_

Thyroid problems? Yes No \_\_\_\_\_

Cardiac (heart) problems? Yes No \_\_\_\_\_

Lung Problems? Yes No \_\_\_\_\_

Breast Problem? Yes No \_\_\_\_\_

Gastrointestinal (stomach) problems? Yes No \_\_\_\_\_

Kidney or bladder disease? Yes No \_\_\_\_\_

Liver problems? Yes No Kidney problems (stones, nephritis)? Yes No \_\_\_\_\_

Hematologic (bleeding, anemia) bleeding problems? Yes No \_\_\_\_\_

Diabetes (insulin dependent/oral medication) Yes No \_\_\_\_\_

Musculoskeletal (bones, joints, muscles) problems? Yes No \_\_\_\_\_

Circulation problems (varicose veins, thrombosis)? Yes No \_\_\_\_\_

Cancer Yes No Type \_\_\_\_\_

High Blood Pressure Yes No \_\_\_\_\_

**(For Women) are you or could you be pregnant?** Yes No \_\_\_\_\_

**(For Women) are your menstrual periods normal?** Yes No \_\_\_\_\_

**Do you have a history of Herpes I or II in the area to be treated?** Yes No \_\_\_\_\_

**Do you have a history of keloid scarring?** Yes No \_\_\_\_\_

**Have you taken Accutane or anticoagulants in the last 6 months?** Yes No \_\_\_\_\_

**Do you have any permanent make-up, implants, or tattoos?** Yes No \_\_\_\_\_

**Have you had any unprotected sun exposure, used tanning** Yes No \_\_\_\_\_

**Creams or tanning beds in the last 4-6 weeks?**

Other Problems \_\_\_\_\_

**PAST SURGERIES OR HOSPITALIZATIONS**

Please list with date:

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY** (check illness which has occurred in any blood relative and write relationship to you):

\_\_\_\_ Cancer \_\_\_\_\_  
\_\_\_\_ Bleeding Disorder \_\_\_\_\_  
\_\_\_\_ Heart disease \_\_\_\_\_  
\_\_\_\_ Diabetes \_\_\_\_\_  
\_\_\_\_ Others \_\_\_\_\_

**SOCIAL HISTORY**

Marital status: S M W D

Occupation \_\_\_\_\_

Tobacco use: Yes No Daily amount \_\_\_\_\_ Number of years \_\_\_\_\_

Alcohol use: Yes No Daily amount \_\_\_\_\_ Drug use \_\_\_\_\_

Caffeine Use: Yes No Daily amount \_\_\_\_\_

Abuse (Describe): \_\_\_\_\_

Other: \_\_\_\_\_

**MEDICATION HISTORY**

Please list all current **medications/herbs** and dosages

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

\_\_\_\_ No known allergies (**NKA**)

\_\_\_\_ Allergies and Reactions to medication, foods, latex, other:

\_\_\_\_\_  
\_\_\_\_\_

**(This next section to be completed by doctor or nurse)**

**PHYSICAL EXAMINATION**

Constitutional: Ht \_\_\_\_\_ Wt \_\_\_\_\_

Temp \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**IMPRESSION:**

\_\_\_\_\_

**PLAN & RECOMMENDATIONS:**

\_\_\_\_\_

**FOLLOW UP** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_