Medical & Surgical Dermatology Center of NE Texas, P.A.
www.dermatologycenteroftx.com

ELECTROLYSIS CASE HISTORY SHEET

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work #: _____

DOB: _____

History Information:

Allergies: _____

Medications: _____

Pregnant: yes no Pacemaker: yes no

Any unusual skin conditions: _____

Ever had electrolysis: yes no When: _____ Method used: _____

What areas were treated: _____ Amount of removal: _____

Check if you have ever had or been treated for any of the following conditions:

☐ Acne	☐ Chest Pain	☐ Hepatitis (Type _____)
☐ AIDS	☐ Circulatory Problems	☐ Herpes (Type _____)
☐ Allergies	☐ Diabetes	☐ High Blood Pressure
☐ Asthma	☐ Epilepsy	☐ HIV
☐ Bleeding Disorder	☐ Fever Blisters	☐ Hodgkins
☐ Cancer	☐ Heart Disease	☐ STD's
☐ Chemo/Radiation	☐ Hemophilia	☐ Tuberculosis

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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