

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____

State _____ Zip Code _____ Email Address _____

Home Phone (____) _____ Work/Other Phone (____) _____ Cell Phone (____) _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

How may we leave messages? (Appointment confirmations, etc.) (Please check all that apply)

Home Phone Work/Other Phone Cell Phone Text Email

What body areas are you mainly interested in for Laser Hair Removal? (Now or in the future) (Please circle)

Arms, Back, Beard, Bikini, Brazilian, Brazilian Extended, Buttocks,, Chest, Chin, Ears, Face, Full Body, Genitalia, Glabella (between brows), Hands, Inner thighs, Legs, Lip, Neck Nose, Pilonidal Cyst, Shoulders, Sideburns, Under-Arms, Other _____

HISTORY

Have you ever had laser hair removal? Yes No

If yes, tell us about it _____

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _____

Do you have tattoos/permanent make-up in the treatment area? Yes No If yes, describe _____

Have you had a recent chemical peel? Yes No

Have you had laser resurfacing in the last year? Yes No

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Are you currently under the care of a dermatologist? Yes No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

Cancer Melanoma Diabetes High blood pressure Herpes Arthritis Frequent cold sores
 HIV/AIDS Keloid scarring Skin disease/Skin lesions Vitiligo Seizure disorder Hepatitis Hormone imbalance
 Thyroid imbalance Eczema/Psoriasis Blood clotting abnormalities Photosensitivity Any active infection Pacemaker/Defibrillator

Do you have any other health problems or medical conditions? Please list. _____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents

Others: _____

For our Female Clients: Are you pregnant or are you trying to become pregnant? Yes No

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones

Others (Please list): _____

Are you on any mood altering or anti-depression medication? Please list. _____

Have you ever used Accutane? Yes No If yes, when did you last use it? _____

What topical medications or creams are you currently using? RetinA

Others (Please list): _____

What herbal supplements do you use regularly? _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature (Guardian Signature if under 18 yrs.) _____ Date: _____