CLIENT INFORMATION

In order to provide you with the most appropriate laser treatment, please complete the following questionnaire.
Please do not answer with N/A (non-applicable)

PERSONAL INFORMATION:

Client Name:_____Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____ City_____

State_____Zip Code_____Email Address_____

Mobile/Text Phone ( )_____Home Phone ( )_____Work/Other Phone ( )_____
If you prefer we do not leave messages (appointment confirmations, etc.) via any of the contact sources listed above, please leave blank or put an "X" through the information. ***2 forms of communication are required.***

Emergency Contact Name and Phone_____

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

Arms, Abdomen, Areola, Back, Beard, Bikini Line, Brazilian, Brazilian Extended, Buttocks, Chest, Chin, Ears, Face, Glabella, Hands, Inner thighs, Legs, Half Legs, Lip, Neck, Pilonidal Cyst, Shoulders, Sideburns, Under-Arms, Full Body
Other areas of concern: _____

PERSONAL HISTORY

Have you ever had laser hair removal? ❑**Yes** ❑**No**

If yes, tell us about it_____

_____

Please check all hair removal methods you've used in the past six weeks.

❑Shaving ❑Waxing ❑Electrolysis ❑Plucking ❑Tweezing ❑Stringing ❑Depilatories ❑None

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 experience Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks following physical trauma? ❑**Yes** ❑**No**

If yes, please describe:_____

Do you have tattoos/permanent make-up in the treatment area? ❑ **Yes** ❑ **No**

If yes please 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 please explain:_____

_____

Are you currently or have you been under the care of a dermatologist in the past year? ❑**Yes** ❑**No**

If yes please explain: _____

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? ❑**Yes** ❑**No**

(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? ❑**Yes** ❑**No**

If yes, please lease list:_____

Have you ever had an allergic reaction to any of the following? ❑**Yes** ❑**No**

Please check all that apply and describe the reaction. ❑Food ❑Latex ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑ Aloe ❑ Other Allergies:_____

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

MEDICATIONS

What prescription and/or OTC (over the counter) oral medications are you presently taking?

❑Birth control pills ❑Hormones ❑Others ❑**None** (Please list) : _____

Are you on any mood altering or anti-depression medication? ❑**Yes** ❑**No** 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 ❑None

(Please list)_____

For photosensitivity evaluation, what herbal supplements do you use regularly? (Biotin, Vitamins, Ect) ❑None

(Please list)_____

** 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 or doctor of my current medical or health conditions and to update this history prior to each treatment.*

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