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 (____)_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

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

❑Home Phone ❑Work/Other 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, Cheeks, Chest, Chin, Ears, Face, Forehead, Full Body, Genitalia, Glabella (between brows), Hands, Head/Scalp, Inner thighs, Legs, Lip, Neck Nose, Shoulders, Sideburns, Under Arms, Other_____

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 ❑Vitaligo

❑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

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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?_____

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?_____

HISTORY

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

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

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:_____