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____________Gender________Occupation_____________________

Home Address____

City____State__________________Zip Code____________

Home Phone (   ) _________________Work Phone (   ) _______________Cell (   )________________

Email Address ____

Emergency Contact Name and Phone____

How were you referred to us? ____

Which of the following best describes your skin type? (Please circle one number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans

MEDICAL HISTORY

Are you currently under the care of a physician? __________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 circle all that apply)

Cancer – Diabetes - High Blood Pressure – Herpes – Arthritis - Frequent Cold Sores - HIV/AIDS –
Keloid Scarring - Skin Disease/Skin Lesions - Seizure Disorder – Hepatitis
Hormone Imbalance – Thyroid Imbalance – Blood Clotting Abnormalities – Any Active Infection

If you have been diagnosed with a Seizure Disorder, you are not a candidate for any laser treatment.

Do you have any other health problems or medical condition? Please list: ________________________

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Have you ever had an allergic reaction to any of the following? (Please circle all that apply and describe the reaction you experienced)

Food – Latex – Aspirin – Lidocaine – Hydrocortisone – Hydroquinone or skin bleaching agents – Aloe

Others:
____

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):

____

HISTORY

Have you ever had laser treatments of any kind? __________Yes __________No

Have you used any of the following hair removal methods in the past six weeks? (Circle all that apply)

Shaving – Waxing – Electrolysis – Tweezing –Depilatories - Threading

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 _________________________

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Do you have any kind of permanent makeup? __________Yes __________No

Do you have any type of Botox or Fillers? _____Yes _____No If yes, last treatment date? __________

For our female clients:
Are you pregnant or trying to become pregnant? _____ Yes _____ No
Are you breastfeeding? _____ Yes _____ No Are you using contraception? _____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 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____Date________________________