Client Information & Medical History

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

PERSONAL HISTORY:

Client Name: ____Todays Date: _________________________

Date of Birth: ______________________Age: ______________Occupation: _________________________

Home Address: ______________________________________ City: ________________________________

Home Phone : ___________________________________ Cell Phone: _____________________________

Emergency Contact (Name & Phone) : ____

How were you referred to us: ____

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

- I ALWAYS BURNS, NEVER TANS
- II ALWAYS BURNS, SOMETIMES TANS
- III SOMETIMES BURNS, ALWAYS TANS
- IV RARELY BURNS, ALWAYS TANS
- V BROWN, MODERATELY PIGMENTED SKIN
- VI BLACK SKIN

MEDICAL HISTORY

Are you currently under the care of a physician? yes no

if yes, for what reason: ____

Are you currently under the care of a dermatologist? yes no

if yes, for what reason: ____

Do you have a history of erythema abigne, which is persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or inferred 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

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 circle all that apply and describe the reaction you experienced)

Food Latex Aspirin Lidocaine Hydrocortisone

Hydroquinone or skin bleaching agents 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 medications? ____________________

Have you ever used Accutane? Yes No ; If Yes, when did you use it last ___________

What topical medications or creams are you currently using? Retina-A
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? Please Circle.

Shaving Waxing Electrolysis Plucking Tweezing Threading 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 hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) marks after physical trauma? Yes No

if yes, please describe: ____

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, 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: __________________________________ Date: ____________________________