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____

Cell Phone (____)_____ Email _____

Emergency Contact Name and 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:_____

_____

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 ❑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 ❑Autoimmune disorders

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**:**_____

_____

MEDICATIONS

What oral medications are you presently taking? ❑Birth control pills ❑Hormones ❑Antibiotics ❑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? ❑ Retin-A® ❑AHA/BHA ❑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 any metal implants? ❑Yes ❑No

Have you had any recent facial procedures, including botox or fillers in the last 4 weeks? ❑Yes ❑No

If yes, date of last procedure: _____

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: _____

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:_____