PATIENT INFORMATION AND HEALTH HISTORY

Personal Information: Date:_____

Name _____ Date of Birth _____ Age_____ Sex _____
Address: _____ _____ _____
Street City Zip

Home Tel: _____ Cell Tel: _____
Email Address :_____ Referred By: _____
Emergency Contact Name/Number: _____
Photographs to show progress: Yes No

Parts you would like to treat:

Eyebrows	Chin	Sideburns	Neck	Bikini Line	Ears	Nose
Upper Lip	Breast	Arms	Stomach	Legs -Lower/Upper		Hairline
Lower Lip	Hands	Back	Toes	Feet	Chest	Underarms

Have you noticed sudden hair growth or changes Yes No
Explain: _____
Problems with skin healing Yes No Explain: _____
Any pre-existing skin conditions (scarring, acne, pigmentation, rash, growths):
_____
Botox, Restylane, Juvederm or other fillers within the last two weeks? If so where _____
Do you have any metal objects in body or body piercings? If so where _____

Medical History:		**Medications:**	**Allergies:**
Pregnant	Herpes	Accutane	Stainless Steel
PCOS	Hepatitis (B-A-C)	Retin A	Topical Anesthetics
Diabetes	High Blood Pressure	Hormone Therapy	Latex
Pacemaker	HIV	Anticoagulants	Cosmetic Products
Fever Blisters	Keloids	Other _____	Witch Hazel
Thyroid			Other_____

Menstrual History: Regular Irregular Menopause
If post menopausal, did you notice increase/decrease of hair? Yes No

Methods Used: Electrolysis Laser Tweezing Threading
Razor Waxing Depilatories Last Used_____

I understand health history is important in order to provide me with safe and effective treatments. I acknowledge all the information given by me is accurate to the best of my knowledge and I agree to update my health history whenever there are changes. I have been advised of the post-treatment healing process, the possible risks to treatment and agree to follow all aftercare instructions and to notify the electrologist of any difficulty in healing.

_____
Patient Signature Date

INFORMED CONSENT FOR ELECTROLYSIS TREATMENT

I am aware that electrolysis involves a series of treatments which can be completed in approximately one to three years depending on what is causing the hair growth and what means of temporary hair removal has been used. Patients that have been tweezing for years will generally require more treatments in that area as the hairs are usually coarse and/or distorted. It is important to stay on a regular schedule due to the cycle in which hair grows. After a series of treatments in which the area has been completely cleared, the regrowth will become less and more time between office visits will be scheduled.

The treatments, expectations from the treatment, and post treatment care have been explained to me and my questions regarding the treatment have been answered to my satisfaction.

I understand that the treatment works on actively growing hairs and follicles and not on any that are dormant. For this reason, it requires several sessions to complete a course of treatment.

I am aware of the following possible risks associated with this treatment including, but not limited to:

Infection - skin infections can occur any time the skin is broken.

Discomfort - some discomfort may be experienced during this treatment. Topical anesthesia may be used if necessary.

Pigment changes (skin color) - during the healing process, the treated areas may become darker or lighter than the surrounding skin. This is usually temporary but, on rare occasions, may be permanent.

I certify that I have read this entire consent form and that all of my questions have been answered, and I understand and agree to the information provided above. I consent to and authorize Electrolysis Center, Claudia Lira and staff to perform electrolysis.

_____

Patient Signature Date