Laser Hair Treatment Admission History Form

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Gender: _____
- Address: _____
- Phone Number: _____
- Email: _____

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone Number: _____

Medical History:

Current Medications:

1. List all medications you are currently taking, including prescription, over-the-counter, and herbal supplements:

   _____

Allergies:

2. Do you have any known allergies (medications, food, latex, etc.)?
    1. Yes
    2. No
3. If yes, please list: _____

Skin Type:

4. How would you describe your skin type? (e.g., dry, oily, combination, sensitive)

   _____

Medical Conditions:

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

1. Diabetes
2. Heart Disease
3. Skin Disorders (e.g., eczema, psoriasis)
4. Keloid Scarring
5. Photosensitivity
6. Epilepsy
7. Others: _____

Previous Procedures:

Have you had any previous laser treatments or cosmetic procedures?

Yes

No

If yes, please specify: _____

Sun Exposure:

Have you used any of the following in the last 6 weeks?

Tanning Beds

Sun Exposure

Self-Tanning Products

Have you ever experienced any complications with hair removal treatments in the past?

Yes

No

If yes, please describe:

Do you have a history of cold sores or herpes simplex virus?

Yes

No

Pregnancy and Nursing:

Are you currently pregnant, trying to become pregnant, or nursing?

Yes

No

Do you have any tattoos or permanent makeup in the treatment area?

Yes

No

Lifestyle and Skin Care:

What is your current skin care routine? (Please list products used):

Do you use any retinoids or exfoliants?

Yes

No

If yes, please specify:

Do you smoke or consume alcohol?

- [ ] Smoke
- [ ] Alcohol
- [ ] Neither

Treatment Goals and Expectations:

What areas do you wish to have treated?

What are your expectations for this treatment?

Have you ever experienced any complications with hair removal treatments in the past?

Yes

No

If yes, please describe:

Additional Concerns:

Do you have any other health concerns or conditions not listed above?

Yes

No

If yes, please describe: _____

Consent for Treatment:

I certify that the above information is true and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may impact my treatment. I consent to the laser hair treatment procedure and understand the risks and benefits involved.

- Patient Signature: _____
- Date: _____
- Reviewed by (Clinician's Name): _____
- Date: _____