LASER / IPL CONSULTATION FORM

Surname _____ First Name _____

Mr/Mrs/Miss/Other _____ DOB ___/___/____

Home Address _____

_____ Postcode _____

Home Tel No _____ Mobile Tel No _____

Email _____

Doctor's Name & Address _____

Emergency Contact Name & Phone Number _____

Ethnic origin _____ Occupation _____

Treatment Requested (please circle)

Hair Removal / Skin Rejuvenation / Vascular / Pigmentation / Acne / Tattoo Removal / Fractional Laser

Other _____ Body Area(s) _____

Lifestyle & Medical History – **PLEASE TICK OR CROSS** in the box as appropriate. If you do not understand or recognise the condition then please discuss with your laser/IPL operator

Pregnant (or planning pregnancy)	☐	PCOS/hormonal imbalance	☐
Sun tanned/using sun beds or fake tan	☐	Thyroid condition	☐
Skin pigmentation disorders (e.g. melasma, vitiligo)	☐	Regular smoker	☐
History of cancer (or chemo/radio therapy)	☐	Psoriasis/eczema	☐
Diabetes	☐	Depression/anxiety	☐
Epilepsy	☐	Herpes (shingles/cold sores)	☐
Lymphatic/immune system disorders	☐	High blood pressure	☐
History of keloid formation/scarring	☐	Photosensitive conditions	☐
Lupus	☐	Allergies _____	
Communicable diseases (hepatitis/HIV)	☐	Units alcohol/week _____	

Useful comments _____

_____

_____

Lynton