FOUNTAIN OF YOUTH – LASER CONSULTATION

DATE.....

NAME .....

Address.....

..... Post Code.....

Mobile ..... Home.....

Email.....

Date of birth .....

Occupation.....

- What body area do you wanted treated? .....
  Hair removal..... Photo Rejuvenation.....Needling.....
  Acne treatment ..... How long have you suffered from Acne?..... yrs
- *Have you previously had treatments? .....*
  If YES, how many and when?.....
- How have you previously removed hair? Wax/pluck/shave/laser/cream/trim
- *What colour is your hair in the area what want treated? Please circle.*

  Black Brown Blonde Grey White Light Brown Light Blonde Red
- Are you.... Please circle?

  Asian European American Middle Eastern African Islander Aust Other
- *Do you currently have a sun tan? No Tan Slight Tan Dark Tan*
  (Remember not to use fake tans throughout your treatment – and NO SOLARIUMS!)
- Have you taken Accutane, Rein-A or other Photo/Light Sensitive medication in the past 6 months? If so, when and for how long?.....
- *Are you currently taken any medication? If so what?.....*
- Are you on blood thinners? If so which one?.....
- *Do you have any illnesses at present or suffer from any medical conditions? If yes, which ones.....*
- Are you a smoker? If so, how many a day .....
- *Are you pregnant or likely to be during your treatment?.....*
- Do you have any implants? .....
- *Have you had any pre-cancerous or cancerous lesions or history of any type of cancer? If so please provide details .....*
- Do you suffer from any of the following... Cold sores/Asthma/Epilepsy/Diabetes/Keloid Scarring/ HIV/Hepatitis/Eczema/Psoriasis

- *Is there anything else of a medical nature we should know about?* .....
- Do you wear sunscreen daily? If so, what brand and SPF .....
- What skincare range do you use? .....
- Do you work outdoors? .....

Would you like to receive discount offers, newsletters and promotional offers .. YES/NO

I, ... agree that the information I have provided above is true and correct.

..... **Date .....**
Signature