

Mike's Electric Chair

Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Hair Removal & You

Have you had laser hair removal in the past? _____

Have you had electrolysis hair removal in the past? _____

Was it successful? _____ Skin reactions? _____

Your Body & Skin

Do you have any of the following skin disorders? Yes / No

Acne Eczema Dermatitis Psoriasis Lipmoas Rashes Keloids Lupus Vitiligo Hives Petechiae Cancer Other If yes, please explain: _____

Do you have any allergies? (Latex, Topical Creams, ect.) Yes / No If yes, please explain: _____

Are you currently using or have ever used Retin-A? Dates: _____

Are you currently using or have ever used Accutane? Dates: _____

Are you currently using or have ever used Rambazole? Dates: _____

Are you currently using or have ever used Absorbica? Dates: _____

Are you currently using any other medication?

Is your hormone function normal? Yes / No If no, please explain: _____

Do you have any electronic or metal devices or implants in your body? Yes / No If yes, please explain: _____

Have you ever talked to your physician about your hair growth? Yes / No please explain: _____

Are you familiar with PCOS _____

Are you currently pregnant or trying to get pregnant? Yes / No

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that it is my obligation to notify Mikes Electric Chair of any changes as it is critical to my treatment. I further agree that all payments are due at time of service.

Client Signature _____

Client Printed Name _____ Date _____