Laser Client Information and Medical History

In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____Today's Date_____

Date of Birth_____ Age_____

Occupation_____

Home Address_____City_____State_____

Zip Code_____Home Phone(____)_____Work Phone(_____)_____

Emergency Contact Name and Phone_____

How were you referred to us?_____

Which of the following best describes your skin type? (please circle one skin type number)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? [ ] Yes [ ] No
Are you currently under the care of a dermatologist? [ ] Yes [ ] No

Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes [ ]

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure moderately intense heat or infrared irradiation? Yes [ ]

Do you have any of the following medical conditions? (Please check all that apply)
[ ] cancer [ ] diabetes [ ] high blood pressure [ ] herpes [ ] arthritis [ ] frequent cold sores
[ ] HIV/AIDS [ ] keloid scarring [ ] skin disease / skin lesions [ ] seizure disorder [ ] hepatitis
[ ] hormone imbalance [ ] thyroid imbalance [ ] blood clotting abnormalities
[ ] any active infection

Do you have any other health problems or medical conditions? Please list: _____

_____

What oral medications are you presently taking? [ ] ACCUTANE [ ] birth control pill
[ ] hormones [ ] others (please list): _____

_____

Have you ever used Accutane? [ ] Yes [ ] No. If yes, when did you last use it?_____

What topical medications or creams are you currently using? [ ] RetinA
[ ] Others (please list) _____

Have you ever had laser hair removal? [ ] Yes [ ] No

Have you used any of the following hair removal methods in the past six weeks? [ ] shaving
[ ] waxing [ ] electrolysis [ ] plucking [ ] tweezing [ ] stringing [ ] depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin?
[ ] Yes [ ] No

Have you recently used any self-tanning lotions or treatments? [ ] Yes [ ] No

Do you form thick or raised scars from cuts or burns? [ ] Yes [ ] No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? [ ] Yes [ ] No, if yes please describe _____

_____

For our Female clients: Are you pregnant or trying to become pregnant? [ ] Yes [ ] No

Are you using contraception? [ ] Yes [ ] No

Are you breastfeeding? [ ] Yes [ ] No

ALLERGIES

Have you ever had an allergic reaction to any of the following? (please check all that apply and describe the reaction you experienced.) [ ] food [ ] latex [ ] cosmetics [ ] aspirin [ ] lidocaine
[ ] hydrocortisone [ ] hydroquinone or skin bleaching agents [ ] others: _____

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date_____