CLIENT INFORMATION AND MEDICAL HISTORY

Client Name: ____ Date: ________________

Date of Birth: ______________ Age: _____ Occupation: ______________________________

Street Address: ____________________________City: _________________ State: ___ Zip: ______

Telephone: (Home) __________________ (Work) _________________ (Cell) __________________

Email Address: ____

Emergency Contact (Name): ____________________________ (Phone) ____________________________

Referred By: ____

MEDICAL HISTORY

Are you currently under the care of a physician? YES NO
If yes, please explain: ____

Are you currently under the care of a dermatologist? YES NO
If yes, please explain: ____

What topical medications or creams are you currently using? RetinA Other __________________________

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? YES NO

Recent Surgery or Injury? ____

Are you currently on any mood altering or depression medications? YES NO

Have you ever used Accutane? YES NO If yes, when did you last use it? ______________________

What herbal/dietary supplements do you use regularly? ____

Present Medications: ____

____

For our female clients:

Are you Pregnant? YES NO If so, due date? __________________
Are you Breastfeeding? YES NO

Regular Periods? YES NO Hysterectomy? YES NO
Over/In Menopause? YES NO Birth Control? YES NO
Metal Implant/Copper UID? YES NO ____

ALLERGIES? (Please circle all that apply)

Food Latex Aspirin Lidocaine Hydrocortizone Hydroquinone or skin bleaching agents

Other: ____

Do you have any of the following Medical Conditions? (Please circle all that apply)

Cancer Treatment Diabetes High Blood Pressure Herpes Arthritis Heart Condition

Frequent Cold Sores HIV/AIDS Keloid Scarring Skin Disease/Skin Lesions Seizure Disorder

Hepatitis (Type?) __________ Hormone Imbalance Thyroid Imbalance Polycystic Ovary Disease

Blood Clotting Abnormalities Pace Maker Acne Any Active Infection

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

____

HISTORY OF HAIR REMOVAL

Do you have any tattoos or body piercings in the areas to be treated? YES NO If Yes, where? ____________________

Have you used any of the following hair removal methods in the past six weeks? (Please circle all that apply)

Shaving Waxing Electrolysis Plucking/Tweezing Stringing Depilatories Bleaching

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

Have you had a chemical or acid peel on your face in the last 3 months? YES NO

If yes, explain where, when and what percent? ____

Do you form thick or raised scars from cuts or burns (keloid)? 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: ____

____

Previous Laser Hair Removal Treatments: (circle one) YES NO

Date Last Treated __________ Areas ____

What are your parents' ethnic backgrounds? ____

LOCATION OF EXCESS HAIR

(Please circle all that apply)

Sideburns Chest Neck Areola Eyebrows Shoulders Gluteal Back

Underarm Full Face Nose Arms Abdomen Ears Bikini Lip Chin Hands

Feet Legs Flanks Sacrum Beard

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 of my current medical/health conditions and to update this history as needed. I understand that a current medical history is essential for the technician to execute appropriate treatment procedures.

I understand that laser hair removal is not immediately permanent and that a series of treatments is necessary to achieve permanent hair reduction. I understand the success of treatments depends largely on my cooperation with my treatment schedule and recommendations by the laser technician. I agree to inform the technician of any changes in my skin after treatment, as well as changes in my general health.

Client Signature: ____ Date: ____________________

Technician Signature: ____ Date: ____________________