CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_______________________________________ Today's Date__________

Date of Birth_______________ Age_____ Occupation_____________________________

Home ____

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 check one)*

- ☐ 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

Do you regularly use tanning salons or sun bathe? ☐ Yes ☐ No If yes, how often?____________

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, for what: ____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No

If yes, for what: ____

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

Do you have any of the following medical conditions?
(Please check all that apply)

☐ Cancer	☐ Frequent cold sores	☐ Seizure disorder	☐ Thyroid imbalance
☐ Diabetes	☐ HIV/AIDS	☐ Hepatitis	☐ Any active infection
☐ High blood pressure	☐ Keloid scarring	☐ Hormone imbalance	☐ ALS or neurological condition
☐ Herpes	☐ Skin disease/ Skin lesions	☐ Blood clotting abnormalities	
☐ Arthritis			

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

____

Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced)

☐ Food ☐ Aspirin ☐ Hydrocortisone

☐ Latex ☐ Lidocaine ☐ Hydroquinone or skin bleaching agents

☐ Others:____

MEDICATIONS

What oral medications are you presently taking? ☐ Birth control pills ☐ Hormones

☐ Others:*(Please list)*: ____

____

Are you on any mood altering or anti-depression medication?

Have you ever used Accutane? ☐ Yes ☐ No If yes, when did you last use it? ______________

What topical medications or creams are you currently using?

☐ Retin-A®

☐ Others:*(Please list)*: ____

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What herbal supplements do you use regularly?

HISTORY

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 ☐ Electrolysis ☐ Tweezing ☐ Depilatories

☐ Waxing ☐ Plucking ☐ Stringing

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: ____

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FOR OUR FEMALE CLIENTS:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you using contraception? ☐ Yes ☐ No

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. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature: ____ Date __________________

Clinician Signature: ____ Date __________________