



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*)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent cold sores | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Thyroid imbalance |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Any active infection |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Hormone imbalance | <input type="checkbox"/> ALS or neurological condition |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Skin disease/
Skin lesions | <input type="checkbox"/> Blood clotting
abnormalities | |
| <input type="checkbox"/> 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)

- | | | |
|--------------------------------|------------------------------------|---|
| <input type="checkbox"/> Food | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Hydrocortisone |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> 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)*: _____

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?

- | | | | |
|----------------------------------|---------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Shaving | <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Tweezing | <input type="checkbox"/> Depilatories |
| <input type="checkbox"/> Waxing | <input type="checkbox"/> Plucking | <input type="checkbox"/> 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: _____



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 _____