

smooth like butter

Laser Hair Removal

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 & Province _____ Postal Code _____

Home Phone _____ Work Phone _____

Emergency Contact Name & 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 (palest white)
- II Always burns, sometimes tans (British, Scottish, reddish)
- III Sometimes burns, always tans (European, medium/beige)
- IV Rarely burns, always tans (Mediterranean, Asian, olive)
- V Brown, moderately pigmented skin (East Indian, Native, light brown)
- VI Black skin (African, Jamaican, dark brown or darker)

What best describes your family heritage (e.g. German, Italian, Asian, British, etc.)?

List, in order of priority, all areas you want treated. Then list areas on your wish list.

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 [] No

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

[] Yes [] No

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 _____