**Client Information and 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Are you currently under the care of a physician? Y\_\_\_\_\_ N\_\_\_\_\_

If yes, for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of erythema abigne, which is a persistent skin rash produced or prolonged by repeated exposure to moderately intense heat or infrared irritation? Y \_\_\_\_N\_\_\_\_

Do you have any of the following medical condition? (Please X all that applies)

\_\_\_\_ Cold Sores \_\_\_\_Cancer

\_\_\_\_HIV/AIDS \_\_\_\_Diabetes

\_\_\_\_Keloid Scarring \_\_\_\_High Blood Pressure

\_\_\_\_Skin Disease/Lesions \_\_\_\_Herpes

\_\_\_\_Seizure Disorder \_\_\_\_Arthritis

\_\_\_\_Hepatitis \_\_\_\_Hormone Imbalance

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

Food\_\_\_\_\_ Latex\_\_\_\_\_ Lidocaine\_\_\_ Hydrocortisone\_\_\_\_ Hydroquinone\_\_\_\_ Metals\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

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

Others (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Have you ever used Accutane? Y \_\_\_ N \_\_\_ If yes, when did you last use it?

What topical medications or creams are you currently using? Retin-A \_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_

What herbal supplements do you use regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History**

Please X by all hair removal methods you’ve used:

History of Laser Hair Removal Yes \_\_\_\_ No \_\_\_\_

Shaving Yes \_\_\_\_ No \_\_\_\_

Waxing Yes \_\_\_\_ No \_\_\_\_

Electrolysis Yes \_\_\_\_ No \_\_\_\_

Plucking Yes \_\_\_\_ No \_\_\_\_

Tweezing Yes \_\_\_\_ No \_\_\_\_

Stringing Yes \_\_\_\_ No \_\_\_\_

Depilatories Yes \_\_\_\_ No\_\_\_\_

Have you had any recent tanning or sun exposure that changed the color of your skin? Y\_\_ N\_\_

Have you recently used any self-tanning lotions or treatments? Y \_\_\_ N \_\_\_

**Female Patients**

Are you pregnant or trying to become pregnant? \_\_\_\_\_\_\_\_ Are you breastfeeding? \_\_\_\_\_\_\_\_\_

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 safe and appropriate treatment procedures.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you be interested in receiving emails about our specials, products, and other laser treatments? Please mark all that apply:

\_\_\_\_\_ Laser Tattoo Removal \_\_\_\_\_ LED Teeth Whitening \_\_\_\_\_ Photo Facials

\_\_\_\_\_ Vein Treatments \_\_\_\_\_ Botox \_\_\_\_\_ Medical Grade Skin Products