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_____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 circle one skin type number)

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

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 [ ]

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

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_____

Name ..... Date .....

	POINTS 0	1	2	3	4	SCORE
What Color are your eyes?	Light blue, grey, green	Blue, grey, green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	
					Total for Genetic Disposition =	

	0	1	2	3	4	SCORE
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Rarely or never	Light color tan	Reasonable tan	Tans very easily	Always turns dark brown	
Do you turn dark brown within several hours of sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to sun exposure?	Very sensitive	Sensitive	Normal	Very resistant	Never had any problem	
					Total for Response to Sun Exposure =	

	0	1	2	3	4	SCORE
When did you lat expose your face/body to sun (include artificial exposure)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Did you expose the area to be treated to sun?	Never	Seldom	Sometimes	Often	Always	
					Total for Tanning Habits =	

Total for Genetic Disposition = _____

Total for Response to Sun Exposure = _____

Total for Tanning Habits = _____

TOTAL SKIN TYPE SCORE = _____

TOTAL SCORE	FITZPATRICK SKIN TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
OVER 30	V-VI

Laser Hair Removal

Pre- and Post-treatment Patient Instructions

Prior to Treatment

- Do not pluck, wax, use a depilatory or undergo electrolysis in the areas you wish to have treated for 6 weeks prior to laser hair removal.
- Do not tan the areas to be treated for 4 weeks prior to treatment.
- Avoid using self-tanning products for 2 weeks prior to treatment.

After Treatment

- Some redness and swelling in the area is normal after treatment and may feel similar to a sun burn. This should resolve within several hours to several days after treatment.
- Gently clean area twice daily.
- Avoid irritants (glycolics, retinoids etc.) for seven days after treatment.
- Apply sunscreen for 6 weeks over the treated area.