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 Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Email _____

Emergency Contact Name and Phone _____

How did you hear about us? Please circle one

INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____

ONLINE YELLOW PAGES DRIVE-BY REFERRED BY: _____

OTHER: _____ IF INTERNET: Google Plus; LinkedIn; Twitter; FACEBOOK; Please circle Any/All → YouTube; Pininterest; Google; YAHOO; website

Which of the following best describes your skin type? (Please circle one type number)

I	Always burns, never tans	IV	Rarely burns, always tans
II	Always burns, sometimes tans	V	Brown, moderately pigmented skin
III	Sometimes burns, always tans	VI	Black skin

How old is your tattoo? _____ Is it homemade or professional? _____

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: _____

Have you ever had a reaction to a previous laser treatment, heat treatment or radiation therapy? ☐Yes ☐No

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

☐Cancer ☐Diabetes ☐Herpes ☐Arthritis ☐Frequent cold sores ☐HIV/AIDS ☐Keloid scarring ☐Skin disease/Skin lesions ☐Seizure disorder ☐Hepatitis ☐Blood clotting abnormalities ☐Any active infection

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

MEDICATIONS

What oral medications are you presently taking? Please List: _____

Have you ever used Accutane? (used for acne) ☐Yes ☐No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐ Retin-A® ☐Others (Please list): _____

Have you ever had an allergic reaction to any medication? Please List: _____

HISTORY

Do you currently have a sunburn? ☐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, 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.

[redacted] _____ [redacted]

Signature. Date.