ROCKY MOUNTAIN LASER COLLEGE
Teaching Laser Technology

CLIENT INFORMATION & MEDICAL HISTORY

All information is strictly confidential

PERSONAL HISTORY

Client Name _____ Today's Date _____

Home Address_____

City_____ State_____ Zip _____ Birth date_____

Mobile number for text appointment reminders (_____) _____

Would you like to receive special discount offers via email? □Yes □ No

Email address_____

Emergency Contact Name and Phone _____

How did you hear about us? _____

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

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

How often do you use tanning salons or sun bathe? □Once a week □Once a month □Seldom/Never

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

Have you taken any **gold therapy** for rheumatoid arthritis? □Yes □No

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

□Cancer □Diabetes □High blood pressure □Herpes □Frequent cold sores □HIV/AIDS □Hepatitis □Keloid scarring □Skin disease/Skin lesions □Seizure disorder □Hormone imbalance □Thyroid imbalance □Blood clotting abnormalities □Any active infection

Please explain _____

_____

PLEASE CONTINUE ON BACK PAGE

Do you have any other health problems or medical conditions that may affect this laser procedure?

Please list: _____

Have you ever had an allergic reaction to any of the following? (Please check all that apply)

□Food □Latex □Aspirin □Lidocaine □Hydrocortisone □Hydroquinone or skin bleaching agents

Explain reaction: _____

MEDICATIONS

Have you ever taken **Accutane**? □Yes □No If yes, when did you last use it?_____

What oral medications are you presently taking? □Birth control pills □Hormones □Others

Please list: _____

Are you on any mood altering or anti-depression medication? □Yes □No What type? _____

What topical medications or creams are you currently using? □ Retin-A® □Others

Please list: _____

What herbal supplements do you use regularly?_____

SKIN HISTORY

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

Have you had Botox, Juvederm or Radiesse injections? □Yes □No When? _____

Have you used any of the following hair removal methods in the past six weeks?

□Waxing □Electrolysis □Plucking □Tweezing □Threading □Depilatories (Nair)

Do you form thick or raised scars (hypertrophic) (keloid) from cuts or burns? □Yes □No

Do you get hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? □Yes □No

Please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? □Yes □No Are you breast feeding? □Yes □No

Are you using contraception □Yes □No What kind? _____

********** PLEASE SIGN BELOW **********

ACKNOWLEDGEMENT:

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. I understand there are NO GUARANTEES for this medical treatment.

Client Signature _____ Date: _____

Medical Director_____ Date: _____