



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: _____