ComplexCity

Great Skin Without Surgery!

Laser Treatments Client Information Form

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 Phone: _____ Work Phone: _____
Home Address_____ City: _____ State: _____ Zip Code: _____
Emergency Contact Name and Phone: _____ How were you referred to us?: _____
Which of the following best describes your skin type? (Please circle one 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.
Do you regularly use tanning salons or sun bathe?: ☐Yes ☐No. How often?: _____

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.
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: _____
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 ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Others: _____

MEDICATIONS

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.
Have you ever used Accutane? ☐Yes ☐No. If yes, when did you last use it?: _____
What topical medications or creams are you currently using? ☐Retin-A® ☐Others (Please list): _____
What herbal supplements do you use regularly?: _____

HISTORY

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 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, 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.

Signature: _____ **Date:** _____