NEW IMAGE
LASER HAIR REMOVAL

Medical History

Date:_____

Last Name:_____ First:_____ Middle:_____
Street Address:_____
City, State, Zip:_____
Home Phone:_____ Work:_____ Cell:_____
Email:_____ Occupation:_____ Date of Birth:_____
Primary Care Physician:_____ Phone:_____
How did you hear about us?_____

Specify your genetic origin:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other

Females:
Are you pregnant? __Yes __No
Are you breastfeeding? __Yes __No
Are you planning pregnancy during the course of your treatment? __Yes __No
During pregnancy, did you develop hyper pigmentation or masking? __Yes __No
Do you have regular periods? __Yes __No
Are you presently going through menopause? __Yes __No

Complete the following items of your medical history. Always inform us of any change in your medical history and/or medications.
List all medications you are currently taking, including prescriptions, over-the-counter drugs, vitamins, herbs and supplements:_____
_____

Please answer the following questions:
1. Are you currently being treated for any medical condition? __Yes __No
   Explain:_____
2. Have you ever seen a physician regarding your skin? __Yes __No
3. Do you have any active skin diseases or infection in the area to be treated? __Yes __No
4. Do you have any skin allergies? __Yes __No
5. Have you had skin cancer or precancerous lesions? __Yes __No
6. Do you have psoriasis/eczema in the area to be treated? __Yes __No
7. Are there any moles with hair in the area to be treated? __Yes __No
8. Are you allergic to latex, lidocaine, or any lotions? __Yes __No
9. Have you ever had surgery in the area to be treated? __Yes __No
10. Have you had any previous skin treatments in the area to be treated? __Yes __No
    Explain and give details:_____
11. Have you/are you using medications such as Accutane? __Yes __No
    Date of last use:_____
12. Are you using Retin-A, Renova, Differin, or Tazorac? __Yes __No
    Concentration: _____%_____

13. Are you using glycolic/AHA home care products? __Yes __No
14. What skin care products are you currently using?_____
_____
15. Do you smoke? __Yes __No
16. Do you sunbathe? __Yes __No
    Approximate date of last sun exposure:_____
17. Are you currently using, or have you used a tanning bed or self-tanner? __Yes __No
18. Do you use sunscreen? __Yes __No
    __Summer SPF:_____ __Winter SPF:___
19. Do you use facial depilatories? __Yes __No
20. Do you use hot wax? __Yes __No
21. Does your skin remain discolored after healing from a cut? __Yes __No
22. Do you currently take any nutritional supplements? If yes please list._____
_____
_____

I confirm that the answers to this questionnaire are true and correct.

Signature of Client:_____ Date:_____

Signature of Consultant:_____ Date:_____