CLIENT QUESTIONNAIRE - Laser Hair Removal

MEDICAL INFORMATION:

NO	YES	
_____	_____	Accutane; If Yes, when? ________________
_____	_____	Allergies
_____	_____	Autoimmune disease, HIV, Lupus, Hepatitis
_____	_____	Currently taking Birth Control Pills or other Hormones
_____	_____	Diabetes
_____	_____	Eczema
_____	_____	Electrolysis; If yes, when? ______________
_____	_____	Glycolic Treatments; If yes, when? ______________
_____	_____	Herpes, Cold Sores, Fever Blisters
_____	_____	Irregular, Pigmented Moles or Growths
_____	_____	Keloids, Pigmented Scars
_____	_____	Migraine Headaches
_____	_____	Currently Pregnancy or Breast Feeding?
_____	_____	Retin-A, Renova; If yes, when? ______________
_____	_____	Shaving (area to be lasered); If yes, when? ______________
_____	_____	Recent Sunburn or tan (area to be lasered); If yes, when? ______________
_____	_____	Tweezing (area to be lasered); If yes, when? ______________
_____	_____	Warts
_____	_____	Waxing (area to be lasered); If yes, when? ______________
_____	_____	Any condition not listed: ___________________________________
_____	_____	Currently under the care of a physician?
_____	_____	Currently taking any medication? ____________________________
_____	_____	Laser procedures, chemical peel, dermabrasion or microdermabrasion?

AREA TO BE TREATED: ____