

## CLIENT QUESTIONNAIRE - Laser Hair Removal

### MEDICAL INFORMATION:

<u>NO</u>	<u>YES</u>	
___	___	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 microderabrasion?

AREA TO BE TREATED: \_\_\_\_\_