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 microderabrasion?

AREA TO BE TREATED: _____