Laser Client Information and Medical History

In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____Today's Date_____

Date of Birth_____ Age_____

Occupation_____

Home Address_____City_____State_____

Zip Code_____Home Phone(____)_____Work Phone(_____)_____

Emergency Contact Name and Phone_____

How were you referred to us?_____

Which of the following best describes your skin type? (please circle one skin 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

MEDICAL HISTORY

Are you currently under the care of a physician? [ ] Yes [ ] No
Are you currently under the care of a dermatologist? [ ] Yes [ ] No

Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted, or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes [ ]

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure moderately intense heat or infrared irradiation? Yes [ ]

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: _____

_____

What oral medications are you presently taking? [ ] ACCUTANE [ ] birth control pill
[ ] hormones [ ] others (please list): _____

_____

Have you ever used Accutane? [ ] Yes [ ] No. If yes, when did you last use it?_____

What topical medications or creams are you currently using? [ ] RetinA
[ ] Others (please list) _____

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 using contraception? [ ] Yes [ ] No

Are you breastfeeding? [ ] Yes [ ] No

Allergies

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 [ ] cosmetics [ ] aspirin [ ] lidocaine
[ ] hydrocortisone [ ] hydroquinone or skin bleaching agents [ ] others: _____

_____

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 as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date_____

SKIN TYPE EVALUATION

NAME : _____ FIRST NAME : _____

Have you ever been treated for a hormone imbalance? No _____ Yes _____

Everyone please answer by circling the answer to each question to determine your skin type:

Score	0	1	2	3	4
What is the color of your eyes	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark brown	Brown black
What is the natural color of your hair	Sandy red	Blond	Chestnut brown, Dark blond	Dark brown	Black
What is the color of your skin in non-exposed areas?	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown
Do you have freckles in the non-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful, blistering, redness, peel	Burns followed by peeling	Burns sometimes followed by peeling	Rare burns	Never has a burn
To what degree do you turn brown?	Hardly at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown
Do you turn brown within several hours after sun exposure?	Hardly or not al all	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has a problem
When did you last expose your body to the sun or sun bed?	More than 3 months ago	2-3 months ago	1-2months ago	Less than one month	Less than 2 weeks ago
Did you expose the area you want treated to the sun?	Never	Hardly ever	Sometimes	Often	Alsways

Total score of all questions: _____

Total Score	Fitzpatrick type
0 – 7	I
8 – 16	II
17 – 25	III
26 – 30	IV
30 et +	V – VI

Hair color in area to be treated :

Blond _____ Light brown _____ Brown _____
Dark brown _____ Black _____ Gray _____

Is the hair: Fine _____ Coarse _____

This section to be completed by clinic staff: These topics were discussed with the client

_____ # of treatments____ Sequencing of treatments ___ Managing hair in between sessions
_____ Hypo/hyper pigmentation _____Redness ___ Blisters _____Change of hair
_____ Potential of stimulation of hair _____ Unsatisfactory result _____Post care
_____ Pain _____ Pictures _____Consent

Name of clinic staff that reviewed this form and did consult _____

Laser Hair Removal

Pre- and Post-treatment Patient Instructions

Prior to Treatment

- Do not pluck, wax, use a depilatory or undergo electrolysis in the areas you wish to have treated for 6 weeks prior to laser hair removal.
- Do not tan the areas to be treated for 4 weeks prior to treatment.
- Avoid using self-tanning products for 2 weeks prior to treatment.

After Treatment

- Some redness and swelling in the area is normal after treatment and may feel similar to a sun burn. This should resolve within several hours to several days after treatment.
- Gently clean area twice daily.
- Avoid irritants (glycolics, retinoids etc.) for seven days after treatment.
- Apply sunscreen for 6 weeks over the treated area.

Laser hair removal consent

Name:_____ First Name:_____

Your permission is necessary before commencing any treatment. The permission form is intended to be a tool to ensure that you are informed about the procedure, the risks and the benefits, and to provide you with a chance to ask your questions.

Laser hair removal is a gradual process. Most individuals require 4 to 8 treatments to reduce their hair from 70 to 85%. The hairs that stay are usually four times thinner and lighter.

There are a few risks with any light base treatment. The majority of individuals have no problems with the treatments. Some people (1%) may experience bruising-which can be very deep purple for a week or sometimes a little longer. Uncommon side effects (2%) would include blistering and pigmentation changes. These are related to your post treatment sun exposure. Rare/unexpected risks would include scarring.

I consent that the Outaouais Medical Aesthetic Clinic takes pictures of the areas to treat for comparison in between treatments. I demand that the clinic ask my permission if they want to use it for other reasons.

I also consent to pay the fees and I understand that they are not refundable.

I understand that if I suffer from genital herpes, I might have to take an antiviral medication before and after the treatment.

I understand that I have to bring my Emla cream if I want to reduce the sensation of discomfort. We can provide you with a prescription.

I agree to use only the shaving technique throughout all the treatments. I was informed that the use of other treatments might take of the base of the hair. In this case, the laser would be ineffective.

I agree to avoid sun exposure during the treatments and I also consent to protect my skin with a sunscreen lotion (SPF 30 or more).

To obtain the best results, I accept the intervals between the treatments as prescribed by the clinic. I agree to follow the post treatment instructions.

Ultimately, we are here to help you and want your experience to be a pleasant one. Please call us with any of your concerns.

In signing, I_____ (print name) give permission to undergo the laser hair removal treatments.

Signature:_____ Date:_____