

## Patient Information – Laser Treatment

(801) 542-7364

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Permission to confirm appointments:  yes  no  
 Referred by:  Person  Yellow Pages  Mailing  New Paper  Other/Explain: \_\_\_\_\_

### General Medical Information

Accutane	<input type="checkbox"/> NO <input type="checkbox"/> YES	Contact Lenses	YES <input type="checkbox"/> NO <input type="checkbox"/>	Heart Condition	<input type="checkbox"/> NO <input type="checkbox"/> YES	Latex Allergies	YES <input type="checkbox"/> NO <input type="checkbox"/>
Acne	<input type="checkbox"/> NO <input type="checkbox"/> YES	Dermatitis/Eczema	YES <input type="checkbox"/> NO <input type="checkbox"/>	Hemophilia	<input type="checkbox"/> NO <input type="checkbox"/> YES	Metal Pins in Body	YES <input type="checkbox"/> NO <input type="checkbox"/>
Canker Sores	<input type="checkbox"/> NO <input type="checkbox"/> YES	Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> NO <input type="checkbox"/> YES	Moles	YES <input type="checkbox"/> NO <input type="checkbox"/>
Carcinoma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Genital Herpes	YES <input type="checkbox"/> NO <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> NO <input type="checkbox"/> YES	Tuberculosis	YES <input type="checkbox"/> NO <input type="checkbox"/>
Cold Sores	<input type="checkbox"/> NO <input type="checkbox"/> YES	Histamine Reaction	YES <input type="checkbox"/> NO <input type="checkbox"/>	Keloid Scars	<input type="checkbox"/> NO <input type="checkbox"/> YES	Pacemaker	YES <input type="checkbox"/> NO <input type="checkbox"/>

### Female Client Medical Information

In Menopause	<input type="checkbox"/> NO <input type="checkbox"/> YES	Pregnant	<input type="checkbox"/> NO <input type="checkbox"/> YES
Post Menopause	<input type="checkbox"/> NO <input type="checkbox"/> YES	Birth Control Pills	<input type="checkbox"/> NO <input type="checkbox"/> YES
Regular Periods	<input type="checkbox"/> NO <input type="checkbox"/> YES	Hormone Pills	<input type="checkbox"/> NO <input type="checkbox"/> YES
Hormonal Imbalance	<input type="checkbox"/> NO <input type="checkbox"/> YES	Endocrine Problem	<input type="checkbox"/> NO <input type="checkbox"/> YES

### Desired Treatment Area (s): (please check and/or circle)

<input type="checkbox"/> Abdomen (Linea)	<input type="checkbox"/> Abdomen (total)	<input type="checkbox"/> Arms
<input type="checkbox"/> Arms (Under)	<input type="checkbox"/> Back (full)	<input type="checkbox"/> Back (Shoulder)
<input type="checkbox"/> Bikini Line	<input type="checkbox"/> Bikini (total)	<input type="checkbox"/> Bikini (labia/anal)
<input type="checkbox"/> Breast (areola)	<input type="checkbox"/> Chest (Pectoral)	<input type="checkbox"/> Chin
<input type="checkbox"/> Ears	<input type="checkbox"/> Eyebrows (mid/full)	<input type="checkbox"/> Feet (Toes)
<input type="checkbox"/> Face (Sides/Full)	<input type="checkbox"/> Hairline (Widows/Peak)	<input type="checkbox"/> Hands (Fingers)
<input type="checkbox"/> Lip (Upper/Lower)	<input type="checkbox"/> Legs (Calves/Thighs)	<input type="checkbox"/> Neck (Front/Back)
<input type="checkbox"/> Nose (Tops/Nostril)	<input type="checkbox"/> Private Areas	<input type="checkbox"/> Other _____

### Previous Treatments for Hair Removal:

Electrology  Shaving  Waxing  E-Tweezers  Sugaring  
 Laser  Tweezing  Depilatories  Epi-Lady  Other

### Existing Skin Condition

Acne  Scarring  
 Rash  Dark Pigmentation  
 Pitting  Pock Marks

### Skin Type

<input type="checkbox"/> Very Light	Type 1
<input type="checkbox"/> Light	Type 2
<input type="checkbox"/> Light to Medium	Type 3
<input type="checkbox"/> Olive to Brown	Type 4
<input type="checkbox"/> Dark Brown	Type 5
<input type="checkbox"/> Very Dark	Type 6

### Preliminary Protocol for Laser Patients

How do you tan?	How do you heal?	Taking any type of drugs?
<input type="checkbox"/> Very Good	<input type="checkbox"/> Very Good	1. _____
<input type="checkbox"/> Fairly Good	<input type="checkbox"/> Fairly Good	2. _____
<input type="checkbox"/> Not Good at All	<input type="checkbox"/> Not Good at All	3. _____
<input type="checkbox"/> Self Tan Method	<input type="checkbox"/> Medical Control	4. _____
	<input type="checkbox"/> Other	

Explain Other/Additional Healing Information: \_\_\_\_\_

### Hypersensitivity and Skin Fragility

Have you ever had a skin allergy or sensitivity?  
 Chemicals  
 Cosmetics  
 Fabrics  
 Other: \_\_\_\_\_  
 Notes: \_\_\_\_\_  
 \_\_\_\_\_

### Treatment Time Frame:

Very Soon  Near Future  Today if Possible

**TO AUTHORIZE LASER TREATMENT, SIGN AFTER READING: \_\_\_\_\_ DATE \_\_\_\_\_**