ADVANCED SPECIALTY CARE

107 NEWTOWN ROAD, SUITE 2C, DANBURY, CT 06810 (203) 791-9661
901 ETHAN ALLEN HIGHWAY, SUITE 101, RIDGEFIELD, CT 06877 (203) 438-5080

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 (___)_________________ Email Address: ___________________________________

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	III	Sometimes burns, always tans	V	Brown, moderately pigmented skin
II	Always burns, sometimes tans	IV	Rarely burns, always tans	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 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? □ Retin A □ 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

<u>Allergies</u>

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, person and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, aesthetician, 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 ______________