BODY LASER & SKIN CLINIC

3917 Old Lee Highway #13-D Fairfax, VA 22030
Phone: (703) 281-5800

Client History Form

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire.

Full Name _____ Today's Date _____

Date of Birth _____ Age _____ SS# _____

Home Address. _____City _____ State _____

Zip Code _____ Home Phone: _____ Work Phone: _____

Email Address_____ How were you referred to us? _____

Emergency Contact Name and Phone # _____

What area(s) are you interested in treating for hair removal?

_____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans
II Always bums, sometimes tans
Ill Sometimes bums, always tans
IV Rarely bums, always tans
V Brown, moderately pigmented skin
VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? Yes_____ No_____

If yes, for what: _____

Are you currently under the care of a dermatologist? Yes____ No____

If yes, for what: _____

Do you have a history of erythema abigne- a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat of infrared irritation? Yes_____ No_____

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Do you have any of the following medical conditions? (Please check all that apply)

Cancer _____	Arthritis _____	Thyroid Imbalance _____
Diabetes _____	HIV/AlDS ____	Skin disease/Skin lesions _____
High blood pressure _____	Keloid scarring _____	Seizure disorder _____
Blood clotting abnormalities _____	Hepatitis _____	Herpes (oral or genital) _____
Any active infection _____	Hormone imbalance _____	

Do you have any other health problems or medical conditions? Please List: _____

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 _____ Aspirin _____ Lidocaine _____ Hydrocortisone ____ Hydroquinone or skin bleaching agents _____ Neosporin_____ Others: _____

Medications

What oral medications are you presently taking?

Birth control pills _____ Hormones _____ St. Johns Wart? _____

Others (please list):_____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? RetinA®_____ Accutane_____

Others (please list) _____

Skin History

Have you used any of the following hair removal methods in the past six weeks?

Shaving_____ Waxing_____ Electrolysis/ Laser_____ Tweezing_____ Treading____ Depilatories_____

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Have you had any recent tanning or sun exposure that changed the color of your skin? 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 breastfeeding? Yes____ No____

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 laser technician of my current medical or health conditions and to update this history. A current medical history is essential for the laser technician to execute appropriate treatment procedures.

Signature _____ Date: _____