Progressive Laser LLC

"Science enhancing Beauty..."

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete 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/Mobile Phone (____) _____ Work Phone (____) _____

Email Address:_____

Emergency Contact Name: _____ Phone: (____)_____
How did you hear about us? _____
Were you referred to us by someone?_____
Name of individual so we may thank them: _____

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: _____

Have you ever had an allergic reaction to any of the following? (Please circle all that apply)
Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or Skin Bleaching Agents
Other: _____

Describe the reaction you experienced:_____

Have you ever had laser hair removal? ❑ Yes ❑ No

Have you used any of the following hair removal methods in the past six weeks? (Please circle all that apply) 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: _____

_____

MEDICATIONS

What oral medications are you presently taking? (Please circle all that apply)

Birth control pills Hormones Others

(Please list): _____

Are you on any mood altering or anti-depression medication?_____ ❑ Yes ❑ No

If yes, 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?

(Please list): _____

What herbal supplements do you use regularly?

(Please list): _____

_____

_____

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

Client Name (Print): _____ Date: _____

Client Signature_____ Date_____