Louisville Laser MED SPA

CLIENT INFORMATION & MEDICAL HISTORY

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Gender _____ Occupation _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( )_ _____

Email Address: _____

Emergency Contact Name and Phone: _____

How did you hear about us? _____

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

If yes, list all conditions for which you currently are being treated and the date of the last visit to a physician for that treatment. Attach extra sheet, if necessary.

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ____☐____ Yes ____☐____ No

If yes, please state how the condition is treated and give the name of your consulting physician

_____

_____

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

☐Cancer ☐Diabetes ☐High Blood Pressure ☐Herpes ☐Arthritis ☐Frequent Cold Sores ☐HIV/AIDS
☐Keloid Scarring ☐Skin Disease/Skin Lesions ☐Seizure Disorder ☐Hepatitis
☐Sexually Transmitted Disease ☐Hormone Imbalance ☐Thyroid Imbalance ☐Blood Clotting
☐Abnormalities ☐Any Active Infection

For all conditions circled, please state how these conditions are treated (medication, etc) and give the name of the physician who is treating you. _____

_____

_____

Have you ever had a seizure or been diagnosed with any seizure disorder? ☐ Yes ☐ No

If you have a seizure disorder laser treatments will not be performed.

If you are taking medication, or have ever taken medication for a seizure disorder, please state the name of the medication and the dates you were prescribed the medication.

Do you have any other health problems or medical conditions which have not been disclosed or discussed above? ☐ Yes ☐ No

If yes, please list all such conditions, the dates you have been treated for those conditions, and the name of the individual who treated you. _____
_____

Have you ever had any allergic reaction to any of the following (please circle all that apply and give the dates of each allergic reaction and how you were treated for same).

☐Food ☐Latex ☐Aspirin ☐Lidocaine ☐Hydrocortisone ☐Hydroquinone or skin bleaching agents ☐Aloe

Others: _____

MEDICATIONS

List all medications you are currently taking, give the name and dosage of that medication and the name of the medical provider who prescribed the medication for you. _____
_____
_____

Have you ever used Accutane: ☐ Yes ☐No If yes, when did you last use it? _____

If you have used Accutane within the last six (6) months, laser treatments will not be performed.

What topical medications or creams have you used within the last 30 days? _____ Retin A, _____
Others (Please list): _____
For each medication listed, please state the last date on which you used it. _____

What herbal supplements do you use regularly? _____

HISTORY

Have you used any of the following hair removal methods in the past six (6) weeks? (Circle all that apply)

☐ Shaving ☐Waxing ☐Electrolysis ☐Tweezing ☐Depilatories ☐Threading

At any time have you had any recent tanning or sun exposure that changed the color of your skin:
_☐_ Yes _☐_ No

If yes, state the date in which it last occurred_____.

Have you recently used any self-tanning lotions or treatments: _☐_ Yes _☐_ No

Have you ever had Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? _☐_ Yes _☐_ No If yes, state the date and circumstances which caused either one of these conditions. _____

Do you have any kind of permanent makeup? _☐_ Yes _☐_ No If yes, please state the kind of make-up you have used, and the date applied last: _____

Do you have any type of Botox or Fillers? _☐_ Yes _☐_ No If yes, last treatment date? _____

For female clients:
Are you pregnant _☐_ Yes _☐_ No
Are you breastfeeding _☐_ Yes _☐_ No

Cosmetic Interest Questionnaire:

What are your areas of concern?
☐ Facials ☐ Chemical Peels ☐ Acne Treatments or Skincare ☐ Anti-aging Scarring ☐ Skin Rejuvenation
☐ Facial Vein ☐ Removal Hair Removal ☐ Blemishes ☐ Tattoo Removal Wrinkle Reduction ☐ Sagging Skin
☐ Dry Skin ☐ Under Eye Darkness Skin ☐ Tightening ☐ Weight Loss Body Sculpting ☐ Minimize Pore Size
☐ Deep Exfoliation

Specialist Recommendations:
1. _____
2. _____
3. _____
4. _____
5. _____

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

Signature _____ Date _____