344 *Beauty Bar*

Laser Hair Removal Consultation

Personal Information

Name: ______________________________________ Home Phone: _________________
Address ____
City: ______________________ State:_______________ Zip Code: _________________
Best number where you can be reached: ______________________________
Date of Birth _______________________ Sex: F M
Referred by: __________________________
Email: ____

Epilation History

Electrolysis__________________ Laser_________________ Waxing _______________

Threading___________________ Plucking _____________ Other__________________

*You must wait 6 weeks following any of the above epilation methods before commencing laser hair removal treatment.

Hair Assessment

Areas to be treated____

____

Hair density: Sparse / Medium / Dense Hair thickness: Fine / Medium / Coarse

Hair color________________ Hair density_________________/ cm2________

*Baseline photos and/or photo documentation is recommended.

Treatment Schedule:

Area

Face / Neck/ BodyLegs –Every 4-6 Weeks

Back- Every 8-10 weeks

Average number of treatments for satisfactory clearance: 4-6

*the above data is a statistical average. Some patients may require less than average or more than average number of treatments to achieve satisfactory clearance. Response to treatment varies depending on medical factors, and skin and hair types. There is also a small percentage of idiopathic non-responders.

Fitzpatrick Skin Type

Please list your ethnicity: __________________________ Mother's ________________________ Father's ______________________

Score	**Analysis**	**0**	**1**	**2**	**3**	**4**
	What is the color of your Eyes?	Light Blue, Grey or Green	Blue, Grey or Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your Hair?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin? (unexposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, Blistering, Peeling	Blistering followed by Peeling	Burns, sometimes followed by peeling	Rarely Burns	Never had Burns
	To what degree do you turn brown?	Hardly or not at all	Light Color Tan	Reasonable Tan	Tan very easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1 Month Ago	Less than 2 Weeks Ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
Total:	**Score**	**Fitzpatrick Skin Type**				
	0 – 7	**I**				
	8 -16	**II**				
	17 – 25	**III**				
	25 – 30	**IV**				
	Over 30	**V - VI**				

Cosmetic/Aesthetic History

Please circle applicable answers:

1. How would you describe your skin? Sensitive Resilient Not sure
2. Describe your skin type:
   oily large pores/oily combination oily/dry normal dry very dry
3. What products or medications do you currently use on your face?
   ____
4. Have you ever had any laser or light based treatment?
   No Yes Type(s) ____________________________
5. Do you sun bathe, go to tanning beds or use tanning lotion? No Yes If yes, when was your last exposure?____
6. Do you have issues with hyper/ hypo pigmentation? (or marks after physical trauma)
   No Yes If so, explain___________________________
7. Have you ever had any facial surgery performed? No Yes Type:________________
8. Have you ever had any type of Aesthetic Procedure/Treatment (including ablative laser)?
   No Yes Type:______________
9. Have you ever had any complications with any Aesthetic Procedures/Treatment in the past?
   No Yes If so, what?__________________________
10. Have you ever had any of the following injectable?
    BOTOX Juvederm Voluuma Other_________

Medical and Family History

1. Are you currently under the care of a physician? No Yes, For: ______________
2. Are you currently under the care of a dermatologist? No Yes, For: ______________
3. Do you have any of the following medical conditions? (Please circle all that apply):

Cancer	Diabetes	High Blood Pressure	Herpes
Cold Sores	Skin Disease/Lesion	Autoimmune Disease (Ex: Lupus)	Skin Cancer
Seizure Disorder	Hormone Imbalance	Thyroid Problems	Arthritis
Acne	Rosacea	Bleeding Disorder	Breathing Disorder
Keloids/Healing problem	Weakened Immune System	Neuropathy	Acute or Chronic Infection
Depression	Anxiety	Panic Attacks	Open Wound

Frostbite	Raynauds Disease	Cryoglobulinemia	Cold Agglutinin Disease

Please list any other health problems or medical conditions (not listed above):

____

____

4. Is there a family history of skin disorders? No Yes, ________________
5. Have you had any recent surgeries? ________________________
6. Do you drink alcohol? No Yes, if so how much/ often?___________
7. Do you smoke? No Yes, if so, how much/ often?___________
8. Do you exercise? No Yes if so how much/often? ___________,
9. Are you pregnant? No Yes
10. Are you currently breastfeeding? No Yes
11. Are you planning to become pregnant? No Yes

12. Do you have any allergies to ANY medications or supplements: No Yes
Please list ALL and indicate type of reaction:
    a. ____________________________________
    b. ____________________________________

13. Do you have allergies to any of the following? If so please indicate your reaction.
    Latex Food (type):__________ Lidocaine
    Hydroquinone Alpha Hydroxy Acid Sulfa
    If so please describe reaction:
    ____

14. Please list ALL medications (including OTC) you are currently taking: None
    Antibiotics Blood Thinners Birth Control Hormones
    Aspirin NSAIDS (Motrin, Advil, Aleve) Anticoagulants
    Benadryl Zantac Amitriptyline Herbal Supplements
    Accutane (in the past 6 months)
    Others (please list):
    ____
    ____

I have answered this questionnaire to the best of my knowledge. I will update the staff with any changes. I understand the answers to this questionnaire are imperative with provided safe quality service.

Patient Signature________________________ **Date**__________

Reviewed with Patient ________________________ **Date**__________

NP/MD Signature________________________ **Date**__________