J K Laser Aesthetics Inc.

CLIENT INFORMATION & MEDICAL HISTORY

To provide 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 ________

Email address: ______________________

Home Phone (___) ____________ Cell / Work Phone (___) ____________

Emergency Contact Name and Phone ________________________________ (___) _________

How were you referred to us? ____

Which of the following best describes your skin type? (Please circle one type 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? ☐No ☐Yes If yes, for what: ______________

____

Are you currently under the care of a dermatologist? ☐No ☐Yes If yes, for what: ______________

____

Do you have a history a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ☐Yes ☐No

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

☐High blood pressure	☐Arthritis	☐HIV/AIDS	☐Keloid scarring
☐Diabetes	☐Cancer	☐Herpes	☐Frequent cold sores
☐Skin disease/Skin lesions	☐Hepatitis	☐Seizure disorder	☐Blood clotting abnormalities
☐Hormone imbalance	☐Thyroid imbalance		☐Any active infection

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

____

Do you have any allergies? ____

MEDICATIONS

What oral medications are you presently taking? ☐Birth control pills ☐Hormones

☐ Others (Please list)____

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

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

What topical medications or creams are you currently using? ☐ RetinA , ☐Others (Please list):

____

What herbal supplements do you use regularly? _______________________________________

____

HISTORY

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

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? ☐ No ☐ Yes

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

Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes If yes, please describe: ________________________________

<u>For our female clients:</u>

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you breastfeeding? ☐ No ☐ Yes

Are you using contraception? ☐ No ☐ Yes

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, esthetician, therapist, doctor or nurse 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.

Signature ________________________________ Date: ___________________