

Medical History for Hair Removal

Patient Name: _____ MR#: _____ Date: _____

What areas would you like treated? _____

What is your expectation of hair removal? _____

Please check any methods you have used for hair removal:

Pluck Shave Threading Electrolysis Wax Depilatory

Do you presently use:

Glycolic products? Yes No

Exfoliant? Yes No

Vaniqua? Yes No

Accutane? Yes No Date last used: _____

Retin A? Yes No Date last used: _____

Please check the following conditions that you currently have or have had in the past:

Acne

Cold sores or herpes, Last outbreak _____, Location _____

Prone to scars (keloids)

Tattoos or permanent make up; location _____

Diabetic

Ingrown hair; location _____

Tested positive for Hepatitis, date _____

Tested positive for HIV, date _____

Thyroid Disease

Sun-exposure Tanning booth Artificial tanning preparation; date last used _____

Pacemaker

Photo-sensitivity disorder (e.g. Lupus)

Folliculitis Beard bumps

Females Only

Currently pregnant Polycystic ovaries Hormonal medications

Have you been evaluated by a gynecologist/endocrinologist/ other physician for an underlying hormonal cause of your excess hair? Yes No If yes, recommended treatment was _____

Check the **ONE** description that would describe you if you were exposed to strong sun with no sunblock:

Always burn and never tan

Always burn and sometimes tan

Sometimes burn, but always tan

Rarely burn, but always tan

Moderately pigmented skin

Darkly pigmented skin

Patient Signature _____ Date _____