Cosmetic Laser Center of Irvine
Client Information
Medical and Skin Care History

Today's Date_____/_____/_____
In order to provide you with the most appropriate laser hair removal or skin care treatment, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.
Client
Name_____Age_____
Email
address_____
Date of Birth____/_____/_____
Phone: Home ( ) _____ Cell ( ) _____
Preferred method of contact: _____
Home Address/ City/ State/ Zip
_____
Occupation_____
Emergency Contact Name and Phone_____
How were you referred to us?
_____
Which of the following best describes your skin type? (Please circle only one skin type number)
1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black skin

MEDICAL HISTORY:

Are you currently or within the last year under a physician's care? [ ] Yes [ ] No
Are you currently being seen by a physician for a medical condition that is not completely diagnosed? [ ] Yes [ ] No
Do you have any of the following medical conditions? (Please check all that apply)
[ ] cancer [ ] diabetes [ ] high blood pressure [ ] herpes [ ] arthritis [ ] frequent cold sores [ ] HIV/AIDS
[ ] keloid scarring [ ] skin disease / skin lesions [ ] seizure disorder [ ] hepatitis [ ] hormone imbalance
[ ] thyroid imbalance [ ] blood clotting abnormalities [ ] any active infection
Do you have any other health problems or medical conditions? Please list:
_____
What oral medications are you presently taking? [ ] Accutane [ ] birth control pills [ ] hormones [ ] others

(please list):

_____

Do you currently have metal implants or a pacemaker? [ ] Yes [ ] No
Have you ever used Accutane [ ] Yes [ ] No. If yes, when did you last use it?
What topical medications or creams are you currently using? [ ] RetinA [ ] others:

_____

ALLERGIES:

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 [ ] cosmetics [ ] aspirin [ ] lidocaine [ ] hydrocortisone [ ] hydroquinone or skin bleaching agents [ ] others:

_____

Reaction:

_____

FEMALE CLIENTS:

Are you pregnant or trying to become pregnant? [ ] Yes [ ] No
Are you currently having or due for your menstrual period? [ ] Yes [ ] No
Are you using contraception? [ ] Yes [ ] No
Are you breastfeeding? [ ] Yes [ ] No

SKIN CARE HISTORY:

Are you currently under the care of a dermatologist? [ ] Yes [ ] No
Do you wear contact lenses? [ ] Yes [ ] No
What temperature of water do you usually cleanse with? [ ] Hot [ ] Warm [ ] Cool
Do you have any special skin problems pertaining to your face? [ ] Yes [ ] No If yes, please specify: _____

_____

Do you have any special skin problems pertaining to your body? [ ] Yes [ ] No If yes, please specify: _____
Have you ever had a chemical peel? [ ] Yes [ ] No
Do you experience breakthrough oily shine during the day? [ ] Yes [ ] No
Do you experience skin breakouts? [ ] Yes [ ] No
What types of skin care products are you currently using? [ ] Soap [ ] Toner [ ] Mask [ ] Cleanser
[ ] Moisturizer [ ] Scrub [ ] Peel [ ] Other: _____
Which Skin Care Product lines are you currently using?

_____

Do you form thick or raised scars from cuts or burns? [ ] Yes [ ] No
When you sunbathe, do you use sunscreen on your skin? [ ] Yes [ ] No
Have you recently used any self-tanning lotions or treatments? [ ] Yes [ ] No
Have you had any recent tanning or sun exposure that changed the color of your skin? [ ] Yes [ ] No
Do you have a tendency to redness? [ ] Yes [ ] No
Have you ever had laser hair removal? [ ] Yes [ ] No
Have you used any of the following hair removal methods in the past six weeks?

[ ] shaving [ ] waxing [ ] electrolysis [ ] tweezing [ ] stringing [ ] depilatories
Do you experience the following skin conditions? [ ] Flakiness [ ] Tightness
[ ] Obvious Dryness
Do you have Hyperpigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) or marks after physical trauma? [ ] Yes [ ] No If yes, please describe _____

MALE CLIENTS:

What is your current shaving system? [ ] Wet [ ] Electric [ ]
Other:_____
Have you ever experienced irritations from shaving or experience ingrown hair? [ ] Yes [ ] No

PERSONAL HABITS:

How many ounces of plain water do you drink daily? _____
How many alcoholic beverages do you drink on average on a weekly basis? [ ] 0 [ ] 1-5 [ ] 6-8 [ ] more than 8
Do you drink caffeinated beverages? [ ] Yes [ ] No If yes, how many daily?____
Do you smoke? [ ] Yes [ ] No -- If yes, how many daily? _____

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 as a current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature: _____

Date:_____