CLIENT HISTORY FORM

LASER and/or MICRODERMABRASION CONSULTATION

LAST FIRST AGE/DOB

ADDRESSS CITY/STATE ZIP CODE

TELEPHONE (preferred method of contact) EMAIL OCCUPATION

HOW WERE YOU REFERRED TO GRAY FAMILY HEALTHCARE, PC

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GENERAL INFORMATION – MICRODERMABRASION *(if not having microdermabrasion procedure performed, please skip to next section)*

Have you had microdermabrasion performed in the past? If so, how long ago?

What particular concerns with your skin you would like to address?

Do you suffer from any of the following problems?

Milia (baby acne)	Comedones (black/white heads)	Acne – Where?	Rosacea	Eczema
Psoriasis	Age Spots	Hyperpigmentation / Hypopigmentation	Moles	Broken Capillaries
Warts	Dry Skin	Oily Skin	Other. Please Specify:	

GENERAL INFORMATION – GentleLASE LASER *(if not having laser procedure performed, please skip to next section)*

Skin Type (I-VI) Fair _____ Olive _____ Dark _____ (Asian/Hispanic) Black _______

Hair Type: Coarse ____ Fine ____ Comments: ____

Hair Color: Black ____ Brown ____ Red____ Blonde ____ Gray ____ Other ________________________________

Because the Candela GentleLASE laser is designed to attract to the pigment in hair and/or skin, please note that laser hair removal is not a successful form of treatment for very light blonde, gray and/or white hair(s).

Do you sunbathe and/or what type of outdoor activities do you engage in?

When was your last exposure to the sun, were you sunbathing or exposed to direct sunlight for a prolonged period of time?

History of keloids/hypertrophic scars:

Area(s) to be Treated: ____

Do you remove hair or have removed hair in the past in the following ways: Wax epilation _____ Mechanical epilation (plucking) _____ Electrolysis _____ Bleaching ___________

Frequency of waxing / what area(s): ____

Frequency of tweezing / what area(s): ____

Frequency of bleaching / what area(s): ____

Last Electrolysis Treatment / what area(s): ____

GENERAL INFORMATION – SKIN CARE

What skin care products are you currently using on your skin and what is your daily skin regimen?

Do you wear sunscreen or makeup containing sunscreen on a daily basis? What SPF?

Are you using or have used Retin-A in the past 3 months? If yes, how often and what percentage?

List any glycolic acid products you are currently using or have used in the past.

Have you ever had any type of chemical peel, if so, what type and when?

GENERAL INFORMATION – HEALTH HISTORY

Are you currently under a physician's care? If yes, for what reason?

List medication and/or vitamins you are currently taking and for what reason?

Please check any health problems, past or present:

Diabetes	Heart Problems	Hepatitis	Thyroid	Cancer
Cysts	Hormonal Problems	Acne	High Blood Pressure	Other: If so, please list

Have you used Accutane in the past 12 months?

Do you suffer from oral herpes, fever blisters or cold sores? If yes, how often and what medication do you take for this? If so, when was your last outbreak?

Do you smoke? If so, how many cigarettes per day?

How much alcohol do you intake?

How much water do you consume a day?

Have you ever had plastic surgery or any type of laser treatment within the last 3 months? If yes, please list the name of your surgeon, physician and/or technician. (specify date/number of treatments/frequency/tissue response)

Are you currently pregnant? If so, how many months. Do you plan to become pregnant within the next year?

Is there anything you feel we need to know to be able to better serve you?

Recommendations (OFFICE USE):

1. ___ Discuss treatment options (testing, color hair responds best, number of treatments).
2. ____Discuss client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
3. ____Review in detail full treatment schedule process (waiting period in-between treatments, when to expect re-growth, shaving ONLY 6 weeks before/after treatment).
4. ____Discuss possible side effects (hyperpigmentation, hypopigmentation, purpura, scaring) and length of time to expect healing if side effects occur.
5. ____Discuss specifics of area to be treated (test small area for tissue response BEFORE full treatment, not eat gas causing foods if treating anal area, protect eyes/eyebrow, nose, ears when treating here).
6. ____Discuss importance of sun exposure avoidance and the use of sunscreen during the entire treatment program.

7. ____Discuss sensation of the laser/DCD spray and the option for topical anesthesia if requested.
8. ____Discuss benefits of laser treatment (possible long-term hair removal), laser safety required.
9. ____ Discus possible alternative treatments (waxing, plucking, electrolysis, referrals, etc.)
10. ____Discuss cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).

COMMENTS:

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I AGREE THAT THE INFORMATION LISTED ABOVE HAS BEEN REVIEWED AND PRESENTED WITH MY CLEAR UNDERSTANDING OF WHAT THIS PROCEDURE INVOLVES. ALL OF MY QUESTIONS HAVE BEEN ADDRESSED TO MY SATISFACTION. I ACKNOWLEDGE THAT ALL OF THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KKNOWLEDGE, THAT I UNDERSTAND FULLY THE PROCEDURE TO BE PERFORMED AND GIVE THE PHYSICIAN / TECHNICIAN OF GRAY FAMILY HEALTHCARE, PC CONSENT TO PERFORM THE REQUESTED SERVICE(S).

CLIENT SIGNATURE   DATE

____________________________________   ____________________

WITNESS   DATE

____________________________________   ____________________