

IPL/Laser History Form

Name: _____ DOB: _____

Ethnicity: _____

What treatment(s) are you interested in (hair removal, vein treatment, photofacial, rosacea treatment, acne treatment)?: _____

On what area(s) of your body? _____

Please describe any problems you have had with any of the following:

- Allergies _____
- Unprotected sun exposure, use of tanning beds, use of self-tanners in areas to be treated _____
- Menstrual dysfunction (hyperandrogenism, hirsutism, etc.) _____
- History of keloid and hypertrophic scar formation _____
- Active infections, open lesions, Herpes I or II within the treatment area _____
- Diabetes _____
- Heat urticaria _____
- Risk of Paradoxical Hair Growth _____
- Hair removal clients only:** Use of mechanical epilation less than six weeks prior to treatment (plucking, waxing, tweezing, electrolysis, etc.) _____
- History of seizures _____
- Current pregnancy _____
- Treatment of skin cancer _____

If you are taking any of the following medications, please circle them.

St. John's Wort

Tetracycline

Accutane

anticoagulants

Retin-A

herbal and natural medications

Plan: *(for physician use only)*
