CONTACT INFORMATION

Name ______________________________ DOB ______________

Address ______________________________ Age ______________

City ______________ State ________ Zip ____________ Gender ______________

Mobile Phone ______________ Other Phone ______________ May we text you? Yes______ No______

Email ______________________________ Occupation ______________

CASE HISTORY

MEDICAL INFORMATION

1 Area(s) to be treated:

☐ Face/Neck ☐ Chest/Breast ☐ Bikini ☐ Abdomen

☐ Thighs/Legs ☐ Arms ☐ Genitals ☐ Other______________

Onset of Hair Growth ______________

2) Menstrual History: ☐ Menarche ☐ Periods Reg ☐ Periods Irregular

Date of cycle

3) Fertility:

☐ Experienced Infertility ☐ Miscarriages (#) ___ ☐ Pregnant ☐ Children (#) __________

4) Do other family members have excessive hair? ☐ Yes ☐ No Relationship______________

5) Check all previous/current methods of hair removal:

☐ Shaving ☐ Tweezing ☐ Epilady ☐ Electronic Tweezers

☐ Clipping ☐ Waxing ☐ Threading ☐ Other______________

Date of last hair removal______________

6) Check all previous laser or electrolysis treatments:

☐ Electrolysis ☐ Laser ☐ Both ☐ None

First treatment date ______________ Last treatment date ______________

7) Have you recently had laser resurfacing? ☐ Yes ☐ No If yes, how long ago? ______________

8) Have you had microdermabrasion/chemical peel? ☐ Yes ☐ No If yes, how long ago? ______________

9) Are you currently using or have you ever used:

☐ Accutane ☐ Retin-A ☐ Renova ☐ Differin

☐ Psoralen ☐ Bleeding Agents ☐ Glycolic Acid

If yes, where was it applied? Please explain ______________________________

10) Do you smoke/vape? ☐ Yes ☐ No If yes, how much per day? ____________

11) Do you drink? ☐ Yes ☐ No If yes, how many per day? ____________

12) Do you get cold sores/fever blisters ☐ Yes ☐ No If yes, last breakout? ________________

13) Are you sensitive to alcohol-based products? ☐ Yes ☐ No

14) Have you had any of the following skin conditions (check all that apply)?

☐ Pigment changes ☐ Eczema ☐ Dermatitis ☐ Keloids ☐ Scars

☐ Psoriasis ☐ Vitiligo ☐ Warts ☐ Other________________________________

MEDICATIONS

☐ Natural Products ☐ Over-the-Counter ☐ Cortisone ☐ Hormones ☐ Oral Contraceptives

☐ Anticoagulants ☐ Anti-inflammatories ☐ Depression/Mood Altering ☐ Other medications

☐ Recreational Drugs ☐ If you checked “other” please list ____

IMPLANTS / SURGERIES

☐ Contact Lenses ☐ Pacemaker ☐ IUD ☐ Metals in Body ☐ Dental Implants

☐ Other Electrical/Medical Implant ____

☐ Cheek/Chin ☐Hysterectomy ☐ Breast ☐ FFS ☐ Orchidectomy

☐ Other Implants/Surgeries ____

MEDICAL CONDITIONS

☐ Epilepsy/Seizures ☐ Nervous Disorder ☐ PCOS ☐ Thyroid ☐ Diabetes

☐ Healing Difficulties ☐ Hemophilia ☐ AIDS/HIV ☐ Herpes ☐ Hepatitis (A-B-C)

☐ Skin Cancer ☐ Cancer/Remission ☐ High Blood Pressure ☐ Other ____________

ALLERGIES

☐ Cosmetics ☐ Metal ☐ Latex ☐ Medications ☐ Iodine

☐ Environment ☐ Food ☐ Fragrance ☐ Animals ☐ Skin Care Products

☐ Other Allergies ____

Patient Signature ________________________________ Print Name ____
*I assert that the information I provided above is complete and accurate to the best of my knowledge.

Who shall we thank for your referral?

Would you like to receive exclusive email and text message notifications ☐ Yes ☐ No