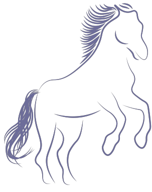

Hair To Bare

In order to provide you with the most appropriate IPL treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL DATA

Client Name: ______________________________ Today's Date: ___________________________

Date of Birth: ______________________ Age _____ Occupation ___________________________

Home Address: ____________________________ City __________ State ______ Zip _________

Cell Phone _____________ Home Phone _____________ Work Phone_____________________

Emergency Contact Name ______________ Phone __________ Relationship ________________

How were you referred to us : ____

Which of the following best describes your skin type? Please circle one type number.

I. Always Burn, Never Tans

II. Always burns, Sometime Tans

III. Sometime Burns, Always Tans

IV. Rarely Burns, Always Tans

V. Brown to Dark Brown, moderately pigmented skin

VI. Dark Brown to Brownish Black Skin

MEDICAL HISTORY

Have you ever had "Tattoo Removal"? Yes ☐ No ☐
If Yes, Where: ____

Are you currently the care of a physician Yes ☐ No ☐
If yes, for what? ____

Are you currently during the care of dermatologist Yes ☐ No ☐
If Yes, for What? ____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? 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? _______________________________

Have you ever had an allergic reaction to any of the following: Please check all that apply, describe the reaction you experienced. Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocorisone ☐ Hydroquinoe or skin bleaching agents ☐

Other ☐ Describe: ____

MEDICATION

What oral medications are you currently taking? Birth Control Pills ☐ Hormones ☐

Others ☐ Please list ____

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 ☐ Please list _______________

What herbal or vitamin supplements do you take regularly? ____

____

SUN, SKIN AND HAIR REMOVAL HISTORY

Have you ever had laser hair removal? Yes ☐ No ☐

Have you ever had an IPL hair removal? Yes ☐ No ☐

Have you used any of the hair removal methods in the past six weeks? Please check all that apply

Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking/Tweezing ☐ Stringing ☐ Depilatories ☐

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes ☐ No ☐ If YES we recommend waiting 4 weeks

Have you recently used any self-tanning lotions or treatments? Yes ☐ No ☐ If yes we recommend waiting 2 weeks

Do you form thick or raised scars from cuts or burns? Yes ☐ No ☐

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes ☐ No ☐ If yes, please describe ____

____

FOR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

Are you using hormone contraception? Yes ☐ No ☐

I certify that the following preceding data, medical history, medication and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history upon every treatment. A current medical history is essential for the technician to execute appropriate treatment procedures.

Printed Name: ____________________ **Signature:** _________________________ **Date:** _______________