CLIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Emergency Contact Name and Phone _____

How did you hear about us? Please circle one

INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____

ONLINE YELLOW PAGES DRIVE-BY REFERRED BY: _____

OTHER: _____

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

I.	Always burns, never tans	IV.	Rarely burns, always tans
II.	Always burns, sometimes tans	V.	Brown, moderately pigmented skin
III.	Sometimes burns, always tans	VI.	Black skin

MEDICAL HISTORY

How long have you had this condition? _____

Have you been treated for nail fungus? Yes No If yes, what type of treatment? _____

Date of treatment _____

Is there a family history of nail fungus? Yes No

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

Are you currently under the care of a dermatologist? ☐ Yes ☐ No If yes, for what: _____

Have you ever had a reaction to a previous laser treatment, heat treatment or radiation therapy? ☐ Yes ☐ No

Do you have any of the following medical conditions: (Please check all that apply)

☐ Cancer ☐ Diabetes ☐ Herpes ☐ Arthritis ☐ Frequent cold sores ☐ HIV/AIDS ☐ Keloid scarring ☐ Skin disease/Skin lesions
☐ Seizure disorder ☐ Hepatitis ☐ Blood clotting abnormalities ☐ Any active infection

Do you have any other health problems or medical conditions? Please list: _____

MEDICATIONS

What oral medications are you presently taking? Please list: _____

Have you ever used **Accutane**? (used for acne) ☐ Yes ☐ No, if yes, when did you last use it? _____

What topical medications or creams are you currently using? ☐ Retin-A ☐ Others (Please list): _____

Have you ever had an allergic reaction to any medication? Please list: _____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant: ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No Are you using contraception? ☐ Yes ☐ No

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, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____