LASER HAIR REMOVAL

Patient Name:_____ Date:_____
DOB:_____

What color is the hair at the treatment site:
Black Brown White Grey Red Other_____

What are you currently using/doing to remove hair at the treatment site?
_____

Any Known medical conditions causing increased risk of hair growth? (hormonal abnormalities, Polycystic Ovary Disease, etc.)? If yes, explain: _____
_____

History of any abnormal lab studies to check hormonal levels? Y N

Are you under the care of a Physician? Y N If yes, Explain:_____

- Photosensitive Disorders? (ie., lupus, sun rash, hives, etc.)? Y N
- Problems with Circulatory System? (ie., Collagen Disease, Raynaud's, Chilblains, etc.) Y N
- Previous Laser treatment? Y N
- Previous electrolysis? Y N
- Are you currently intentionally tanning? (tanning beds, laying out, etc) Y N
- Do you wear a broad spectrum sun block every day? Y N