PATIENT QUESTIONNAIRE – Non-Ablative Laser Procedures
Patient Name ________________________________Date___________
Area(s) to be treated? ____

MEDICAL INFORMATION:
NO YES
_____ _____ Accutane in the past 6 months?
_____ _____ Allergies ____
_____ _____ Autoimmune disease, **HIV, Lupus, Hepatitis, Other________________**
_____ _____ Currently taking Birth Control Pills or other Hormones
_____ _____ Diabetes
_____ _____ Eczema
_____ _____ Electrolysis; **If yes, when?** _______________________________
_____ _____ Glycolic Treatments; **If yes, when?** _________________________
_____ _____ Herpes, Cold Sores, Fever Blisters
_____ _____ Irregular, Pigmented Moles or Growths
_____ _____ Take Anticoagulants
_____ _____ Take medication that is known to increase sensitivity to sunlight
_____ _____ Have seizure disorders triggered by light
_____ _____ Are receiving or have received Gold Therapy
_____ _____ Are taking isotretinoin or have in the past six months
(Acne medication)
_____ _____ Keloids, Pigmented Scars
_____ _____ Migraine Headaches
_____ _____ Currently Pregnant or Breast Feeding?
_____ _____ Retin-A, Renova; **If yes, when?** ___________________________
_____ _____ Shaving **(Area to be lasered); If yes, when?** _______________________
_____ _____ Recent Sunburn or tan **(Area to be lasered); If yes, when?** ______________
_____ _____ Use of self tanners? **(Area to be lasered) If yes, how long ago?** ___________
_____ _____ Tweezing **(Area to be lasered); If yes, when?** _______________________
_____ _____ Warts

-Continued-

MEDICAL INFORMATION:
NO YES

_____ _____ Waxing **(Area to be lasered); If yes, when?** ____________________________
_____ _____ Any condition not listed:____

_____ _____ Currently under the care of a physician? For?____________________
____
_____ _____ Laser procedures, chemical peel, dermabrasion, microdermabrasion or dermaplaining? How recent? ____

_____ _____ Currently taking any medications? If so, please list all medications, supplements and/or vitamins. (Please Print Clearly)

____

____

____

____

____

____

____

Patient or Patient Guardian

Signature____

Date_________________________________

Laser Technician Signature ______________________________________