

**PREFERRED WOMEN'S HEALTHCARE
500 MEDICAL CENTER BLVD, SUITE 290
LAWRENCEVILLE, GA 30046
(770) 962-5100**

LASER HAIR REMOVAL ASSESSMENT FORM

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ WORK TELEPHONE _____

WHAT AREA/AREAS DO YOU WISH TO HAVE TREATED? _____

ARE YOU CURRENTLY UNDER CARE OF ANOTHER PHYSICIAN? (Y / N) IF YES, PLEASE EXPLAIN:

PLEASE LIST ANY MEDICATIONS YOU HAVE TAKEN, AND WHEN YOU LAST TOOK THEM, ESPECIALLY ACCUTANE (ISORETINOIN), PHOTSENSITIZING DRUGS, ST JOHN'S WORT, GOLD SALT INJECTIONS, HERBALIFE, METABALIFE AND DIURETICS.

DO YOU USE GLYCOLIC PRODUCTS, EXFOLIATING PRODUCTS, OR RETIN-A? _____

ARE YOU PREGNANT? _____ HAVE YOU HAD HERPES OR COLD SORES IN THE TREATMENT AREA? _____

DO YOU HAVE ANY UNUSUAL SCARS? _____ WHERE? _____ EXPLAIN: _____

PLEASE LIST ANY ALLERGIES (ESPECIALLY ANESTHETICS) _____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD:

IRREGULAR PERIODS	Y/N	HYSTERECTOMY	Y/N	HEPATITIS	Y/N
HISTORY OF HIVES	Y/N	PACEMAKER	Y/N	DIABETES	Y/N
KELOIDAL SCARRING	Y/N	HIV/AIDS	Y/N	HERPES	Y/N
CANCER/MELANOMA	Y/N	COLD SORES	Y/N	HIGH STRESS	Y/N
LASER RESURFACING	Y/N	HEART PROBLEMS	Y/N	HYPERTENSION	Y/N
MENOPAUSAL SYMPTOMS	Y/N	FILLINGS, CROWNS, METAL PINS	Y/N		
RELATIVES WITH UNWANTED HAIR	Y/N	INCREASE IN AMOUNT OF HAIR	Y/N		

HISTORY OF SKIN CANCER OR ATYPICAL MOLES? _____ EXPLAIN: _____

ANY TATTOOS OR PERMANENT MAKE UP? _____ Y/N

PHOTOSENSITIVE DISORDER (LUPUS, SUN RASH)? VITILIGO? SCLERODERMA? _____ Y/N

UNUSUAL SKIN/SYSTEMIC CONDITIONS? _____ EXPLAIN: _____

PREVIOUS LASER, PLUCKING, WAXING, OR ELECTROLYSIS TREATMENTS? _____ WHEN? _____

RECENT EXPOSURE TO SUN OR TANNING BOOTH? _____ WHEN? _____ DO YOU HAVE A TAN? _____

SELECT THE **ONE** DESCRIPTION THAT WOULD DESCRIBE YOU IF YOU WERE EXPOSED TO STRONG SUN WITH NO SUNBLOCK:

1. ALWAYS BURN AND NEVER TAN _____ 2. I ALWAYS BURN AND SOMETIMES TAN _____

3. I SOMETIMES BURN, BUT I ALWAYS TAN _____ 4. I RARELY BURN, BUT I ALWAYS TAN _____

5. I HAVE MODERATELY PIGMENTED SKIN _____ 6. I HAVE DARKLY PIGMENTED SKIN _____

WHAT IS YOUR ETHNIC ANCESTRY? _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY TECHNICIAN RELIES ON THIS FOR SAFE AND EFFECTIVE TREATMENT.

SIGNATURE: _____

DATE: _____

PRINT NAME: _____