LASER

INTERLOCKS ™
MEDSPA + WELLNESS

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ______________________________

Street Address: ____

City : ______________________________ State: ____________________ Zip Code: ____________

Home Phone: ______________________________ Okay to leave confidential message? Y / N

Cell Phone: ______________________________ Okay to leave confidential message? Y / N

E-Mail: ____

Emergency Contact *Name:* ____________________ *Phone #:* ____________________

Which of the following best describes your skin type?

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

MEDICAL HISTORY

Are you currently under the care of a physician? Y / N

If yes, please explain: ____

Are you currently under the care of a dermatologist? Y / N

If yes, please explain: ____

Do you currently have any fillers or Botox®? Y / N

Please answer YES or NO to the below medical history questions:

	Y	N	N/A
Do you have a history of erythema ab igne?			
Have you had significant sun exposure (tanning) in the last 4 to 6 weeks?			
Do you have tattoos or permanent makeup in areas to be treated?			
Do you ever have cold sores or fever blisters?			
Are you currently pregnant or trying to conceive?			
Are you currently breastfeeding?			
Are you using a contraceptive?			
Do you have metal implants (Ex. copper IUD, piercings) or other implants?			

Do you have any of the following medical conditions? Please check all that apply.

Cancer
Any Active Infection
High Blood Pressure
Arthritis
History of Melanoma
Gold Therapy
Frequent Cold Sores
Keloid Scarring
Coagulopathies
Skin Disease/Skin Lesions
Seizure Disorder
Hormone Imbalance
Thyroid Imbalance
Pacemaker/Defibrillator
Blood Clotting Abnormalities
Vitiligo
HIV/AIDS
Herpes
Diabetes
Hepatitis

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

____

Have you ever had an allergic reaction to any of the following medications? Please check all that apply and describe the reaction you experienced.

Food	
Latex	
Asprin	
Lidocaine	
Hydrocortisone	
Hydroquinone/skin bleaching agents	
Other	

MEDICATIONS

Are you currently on any blood thinners? Y / N Please list all. ____

____

What oral medications are you presently taking? Please include hormones and/or birth control if applicable.

____

____

Are you on mood altering or anti-depressant medication? Y / N

Have you ever used Accutane? Y / N If yes, when did you last use it? ________________________________

Are you currently using RentialA or any other topical medications or creams? Please list all. ______________

____

What herbal supplements do you use regularly? ____

____

LASER + HAIR REMOVAL HISTORY

Have you ever had laser hair removal and/or laser treatments? Y / N

Have you ever had electrolysis? Y / N

Have you used any of the following hair removal products in the past six weeks? (Check all that apply)

Shaving	Electrolysis	Tweezing	Depilatories
Waxing	Plucking	Stringing	Laser Hair Removal

Have you had any recent tanning or sun exposure that changed the color of your skin? Y / N

Have you recently used any self-tanning lotions or treatments? Y / N

Do you form thick or raised scars from cuts or burns? Y / N

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Y / N If yes, please describe: ____

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

Signature:____ Date: ____________________