Nancy Aria, MD, PC & James Aria, MD, PC
Laser Hair Reduction Consultation

Personal Information:

Name:_____

Home Phone:_____ Work/Cell Phone:_____

Address:_____
City State Zip

Date of Birth:_____ Sex: Female Male

E-Mail:_____
Allergies: _____
How did you hear about the practice:_____
Emergency Contact (Name and Phone number):_____

Treatment Area Desired:_____

Medical History:

Are you currently under the care of a physician? Y____N____
If yes, for what?:_____

Do you have a history of skin rash caused by exposure to heat or infrared radiation? Y____ N_____
Have you had any recent tanning or sun exposure? Y____ N_____
Have you used any self-tanning lotions or treatments? Y____ N_____

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

□ Bleeding Disorder/Bruise easily	□ Endocrine/Hormone Issues/Hormone Imbalance
□ Pigmentation Disorder	□ Pacemaker/Defibrillator
□ History of Cold Sores	□ History of Keloid Scarring
□ Have Taken Accutane in the last 6 months	□ History of Skin Cancer
□ Photoallergic	□ HIV/AIDS
□ Cancer ; Type:_____	□ Diabetes
□ High Blood Pressure	□ Herpes
□ Seizure Disorder	□ Arthritis
□ Hepatitis	□ History of hyper/hypopigmentation
□ Thyroid Imbalance	□ Any active infection
□ Other:_____	□ Any other Dermatological Conditions_____

Current oral medications (over the counter/prescription/herbal):
_____
_____
Are you using any mood altering or anti-depression medication? If yes, what?:_____
What topical medications or creams are you currently using, if any?_____
Allergies: _____

Female Patients:
Are you pregnant or trying to become pregnant? Y____ N____
Are you breastfeeding Y____ N_____

Hair Removal History

Please check the hair removal methods you've used. If yes, when was the last time used?

Treatment	Yes	No
Laser Hair Removal		
Shaving		
Waxing		
Electrolysis		
Plucking		
Tweezing		
Stringing		
Depilatories		

I certify that the proceeding medical, personal and skin history statements are true and correct. I am aware that its is my responsibility to inform the technician of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute safe and appropriate treatment procedures.

Signature:_____ Date:_____