

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

Personal Information:

Name: _____

Home Phone: _____ Work/Cell Phone: _____

Address: _____

Date of Birth: _____ Sex: Female Male City State Zip

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):

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