Stephanie Cogliano Laser and Electrology Associates

Howard S. Goldberg, M.D., Medical Director

CLIENT INFORMATION & MEDICAL HISTORY

FOR ELECTROLOGY & LASER HAIR REMOVAL

In order to provide you with the most appropriate laser and skin care treatments, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____

Date of Birth _____ Occupation _____

Home Address _____ City _____ State ___ Zip_____

Home Phone (____)_____ Work Phone (____)_____

Cell Phone (____)_____ Email _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? Please circle one type.

1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black Skin

MEDICAL HISTORY

Are you currently under the care of a physician ____ yes ___ no

If yes, for what: _____

Are you currently under the care of a dermatologist? ____ Yes ____ No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? _____Yes _____ No

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

___Cancer ____Diabetes ___ High Blood Pressure ____ Herpes _____Arthritis ___ Frequent Cold Sores

____HI V/AIDS ____Keloid scarring ____Skin disease/Skin Lesions ___Seizure disorder ___Hepatitis
___Hormone imbalance ___Thyroid imbalance ___ Blood clotting abnormalities ___ Any active infection

Have you had significant sun exposure in the last 4 to 6 weeks? _____ Yes _____ No

Do you have tattoos or permanent makeup in areas to be treated? _____ Yes ___ No

Do you ever had cold sores or fever blisters? _____ Yes _____ No

Are you currently pregnant or trying to conceive? _____ Yes _____ No

Are you breastfeeding? ____ Yes ____ No Are you using contraception? _____ Yes _____ No

Do you have implants? ____ Yes _____ No

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

_____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) _____ Food _____ Latex _____ Aspirin _____ Lidocaine ____ Hydrocortisone

_____ Hydroquinone or skin bleaching agents _____ Others: _____

MEDICATIONS

What oral medications are you presently taking? ____ Birth control pills ____ Hormones _____ Others

Please list: _____

Are you on mood altering or anti-depression medication? _____ Yes ___ No

Have you ever used Accutane? ___ Yes ___ No If yes, when did you last use it? _____

What topical medications or creams are you currently using? _____ RetinA ____ Others (Please list): _____

_____

What herbal supplements do you use regularly? _____

HISTORY

Have you ever had laser hair removal? _____ Yes _____No

Have you used any of the following hair removal products in the past six weeks?

___ Shaving ___ Waxing ___ Electrolysis ____ Plucking ____ Tweezing ____ Stringing ___ Depilatories

Comments: _____

Have you had any recent tanning or sun exposure that changed the color of your skin? _____ Yes _____ No

Have you recently used any self-tanning lotions or treatments? _____ Yes _____ No

Do you form thick or raised scars from cuts or burns? _____ Yes _____ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? _____ Yes _____ No 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 or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____