

Client Information

First Name _____ M.I. _____ Last Name _____ Age: _____ Sex: M / F

Home Address _____ Date of Birth: ____ / ____ / ____

City _____ State ____ Zip _____

Preferred contact Cell Phone: _____ (carrier): _____

Preferred contact Email: _____

Allergies/Reaction: _____ Occupation: _____

Emergency Contact: _____ Telephone: _____

How did you hear about *Capital Laser*? Google Yelp Friend/Family: _____

1. What areas on your body are you interested in treating? _____

2. What other treatments, if any, have you tried? _____ When: _____

3. Please circle the following if applicable: sunburn windburn self-tanner tanning bed

4. Have you used Renova or Retin A, Alpha-Hydroxy, glycolic acid? When/Where? _____

5. Are you or have you ever used Accutane? _____ When: _____ Dosage _____

6. Are you currently taking any of the following? __ Tetracycline __ Bactrim __ Hydrochlorothiazide

7. Are you currently taking any depression medications or other mood altering medication? _____
Why? _____

8. Please list any other medications or herbal supplements that you are currently taking (including topical):

Medical History:

Please put a check (✓) next to a past or current medical condition(s):

- | | |
|---|--|
| <input type="checkbox"/> Lupus or other autoimmune deficiency | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Currently Pregnant/breastfeeding | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bleeding abnormalities | <input type="checkbox"/> Scars that turn white or brown |
| <input type="checkbox"/> Keloid or very thick scarring | <input type="checkbox"/> Dark spots after pregnancy, skin injury |
| <input type="checkbox"/> Psoriasis or Vitalgo | <input type="checkbox"/> Hirsutism |
| <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> Transplant Anti-Rejection Drugs |

This information is true to the best of my knowledge.

Signature: _____

Date: _____