Client Information

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

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

City_____ State _____ Zip_____

Cell Phone: _____ Occupation: _____

Email: _____

Allergies/Reaction: _____

Emergency Contact: _____ Telephone:_____

How did you hear about ***Capital Laser***? Google,Yelp,Friend/Family,Social Media:

_____

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):

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

This information is true to the best of my knowledge.

Signature: _____ Date:_____

Please continue reverse side