Laser Lounge Med Spa ○ 2002 Williams Dr. Georgetown, TX 78628 ○ 512-863-2118

Client Information

Name____Date_______________

Name of Guardian if under 18 years old ____

Date of Birth __________________Age _____________ Occupation ________________

Home Address ____

City ___________________________ State ____________ Zip ____________________

Preferred contact phone # ____

Is it ok to leave a message on this phone or with the person who answers it, if it is not yourself?

______ Yes ______ No

To receive 50% off select services for your birthday, appointment reminders, and our monthly newsletter please provide your email ____

If you would like to receive appointment reminders by text please provide your cell phone number ____

Emergency contact name and phone number____________________________________

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Who can we thank for referring you? ____

Fitzpatrick Scale: which of the following best describes your skin type? (Please circle one)

I Always burns, never tans (palest; freckles)
II Usually burns, tans minimally
III Sometimes mild burn, tans uniformly
IV Burns minimally, always tans well (moderate brown)
V Very rarely burns, tans very easily (dark brown)
VI Never burns (deeply pigmented dark brown to darkest brown)

Medical History

Are you currently under the care of a physician? Yes No

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

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

Arthritis	Hepatitis	Keloid Scarring	Frequent Cold Sores
Cancer	Herpes	Hormone Imbalance	Blood Clotting Abnormalities
Diabetes	Skin Disease	Thyroid Imbalance	Any Active Infection
HIV/AIDS	Seizure Disorder	High Blood Pressure	

Do you have any other health problems or medical conditions? If yes, please list

____

What oral medications are you presently taking? (Circle all that apply)

Accutane Hormones Antibiotics Steroids

Other ____

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

What topical medications and/or creams are you currently using? (Circle all that apply)

Retin-A Renova Others ____

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the last 6 weeks?

Shaving	Waxing	Electrolysis
Tweezing	Stringing	Depilatories

Have you had any recent tanning/sun exposure that changed the color of you 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 hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes, please describe ____

Do you have any food, drug, or cosmetic allergies? Yes No

If yes, please list all

For Female Clients

Are you pregnant or trying to become pregnant? Yes No

Are you on oral birth control pills? Yes No

Are you breast feeding? Yes No

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 technician, esthetician, therapist, or doctor of my current medical or health conditions and to update this history as current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand if I fail to provide any changes to my medical profile my caregiver that no liability will fall on my caregiver.

Patient Signature Date