Health and Medical History

Name:_____ Date:_____

Ethnic Origin: Caucasian African American Hispanic Asian Other

Fitzpatrick Skin Type: circle one

Skin Type	Observation	Skin Color
I	Always burns, never tans	Pale white
II	Burns easily; tans minimally	White to light beige
III	Burns moderately; tans gradually to light brown	Beige
IV	Burns minimally; tans well to moderately brown	Light to medium brown
V	Rarely burns; tans profusely to dark brown	Moderate brown
VI	Never burns; tans profusely	Dark brown or black

Medical History

Check the appropriate box next to any condition for which you have ever been treated:

0 Acne
0 Blood Disorders
0 Burns/skin graft
0 Skin Pigmentation
0 Diabetes
0 High Blood Pressure
0 Steroid or Hormonal Therapy
0 Hirsutism
0 Hepatitis
0 Keloid formation
0 Kidney disease
0 Hormonal Imbalance
0 Psoriasis
0 Polycystic Ovarian Syndrome
0 Shingles
0 Cancer
0 Herpes
0 Epilepsy
0 Melanoma
0 Vitiligo
0 MRSA

(Clients should not be taking Accutane, or Photosensitizing medications. Clients on Anti-Coagulants should be noted.)

1. Are you currently being treated for a condition not listed? If yes, please specify:

2. Are you currently taking any medications? (include natural or herbal) If yes, please specify:
   With the medications, do you have any photosensitivity to light?

3. Do you have any allergies? If yes, please specify:

4. Have you ever used (or are you currently using) RetinA or glycolic acid? If yes, please specify: (if yes, discontinue use for 2 weeks prior to your pulsed light treatment)

5. Have you ever used or are you currently using accutane? If yes, please specify: (clients need to be off accutane 6 months prior to your pulsed light treatments)

6. Do you have a history of keloid formations?

7. Have you had any epileptic seizures? If yes, please specify:

8. When was the last time you waxed, plucked, or used a depilatory on the area to be treated? (can't use epilation 4-6 weeks prior to pulsed light treatments)

9. Do you have a menstrual dsyfunction? If yes, please specify:(you may need to see an endocronologist for additional help regarding hirsutism)

10. Do you have any tattoos or permanent makeup in the area to be treated? If yes, please specify:

11. Do you have any skin sensitivities? If yes, please specify:

12. Do you have outbreaks of Herpes I or II within the treatment area? If yes, please specify:(contact your primary care provider for appropriate medication prior to your treatment)

13. Have you undergone or are you currently undergoing chemotherapy treatment? If yes, please specify

14. Do you have any active infections? If yes, please specify:(you will need to wait until the infection is cleared)

15. Are you pregnant?

16. Are you currently on any mood altering or depression medication?

Signature:_____Date:_____