



Vanish

Laser Tattoo Removal & Skin Aesthetics

CLIENT INFORMATION & MEDICAL HISTORY

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

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Email _____

Would you like appointment reminders by text? _____ If yes, who is your cell provider? _____

Emergency Contact Name, relationship, and Phone _____ (____) _____

How did you hear about us? Please circle one: ONLINE YELLOW PAGES DRIVE-BY

INTERNET SEARCH (Google / Yahoo / MSN): Search Term Used: _____

REFERRED BY: _____ OTHER: _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans IV Rarely burns, always tans
- II Always burns, sometimes tans V Brown, moderately pigmented skin
- III Sometimes burns, always tans VI Black skin

How old is your tattoo? _____ Is it : (circle 1) homemade or professional?

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: _____

Have you ever had a reaction to a previous laser treatment, heat treatment or radiation therapy? Yes No

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

- Cancer Diabetes Herpes Arthritis Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions Seizure disorder
- Hepatitis Blood clotting abnormalities Any active infection

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

MEDICATIONS

What oral medications are you presently taking? Please List: _____

Have you ever used Accutane? (used for acne) Yes No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin-A® Others (Please list): _____

Have you ever had an allergic reaction to any medication? Please List: _____

HISTORY

Do you currently have a sunburn? 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: _____

For our female clients:

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No Are you using contraception? Yes No

ALL CLIENTS: 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, 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: _____