PATIENT QUESTIONNAIRE – Non-Ablative Laser Procedures
Patient Name_____Date_____
Area(s) to be treated? _____

MEDICAL INFORMATION:
NO YES

_____ _____ Accutane in the past 6 months?
_____ _____ Allergies _____
_____ _____ Autoimmune disease, **HIV, Lupus, Hepatitis, Other**_____
_____ _____ Currently taking Birth Control Pills or other Hormones
_____ _____ Diabetes
_____ _____ Smoke cigarettes; **if yes how many a day?**_____
_____ _____ Eczema
_____ _____ Electrolysis; **If yes, when?** _____
_____ _____ Glycolic Treatments; **If yes, when?** _____
_____ _____ Herpes, Cold Sores, Fever Blisters
_____ _____ Irregular, Pigmented Moles or Growths **(in treatment area)**
_____ _____ Keloids, Pigmented Scars
_____ _____ Migraine Headaches
_____ _____ Currently Pregnant or Breast Feeding?
_____ _____ Retin A, Renova; **If yes, when?** _____
_____ _____ Shaving **(Area to be lasered); If yes, when?** _____
_____ _____ Recent Sunburn or tan **(Area to be lasered); If yes, when?** _____
_____ _____ Use of self tanners? **(Area to be lasered) If yes, how long ago?** _____
_____ _____ Tweezing **(Area to be lasered); If yes, when?** _____
_____ _____ Warts
_____ _____ Waxing **(Area to be lasered); If yes, when?** _____
_____ _____ Any condition not listed:_____
_____ _____ Currently under the care of a physician? For?_____
_____
_____ _____ Laser procedures, chemical peel, dermabrasion, microdermabrasion or dermaplaining? How recent? _____

OVER

MEDICAL INFORMATION:

YES NO

_____ _____ Currently taking any medications? If yes, please list any medications, supplements and/or vitamins and what they are taken for.

PLEASE PRINT CLEARLY

_____
_____
_____
_____
_____

Patient Signature_____ Date_____

Laser Technician Signature _____