# CONFIDENTAL CASE HISTORY

## General Information

Name_______________________________________________Date____________
Address______________________________________________________________
City____________________Zip Code_____________Birth Date_________________
Occupation______________________Home phone______________Cell__________
Age_________Race_________
How were you referred?  Person___Yellow pages_____Other______________
Physician's Name_____________________________

## Medical

*Circle yes or no*

**Desired Treatment Area** *circle which applies*

*Abdomen  Ears  Mustache  Chin  Arms: Fore/Under  Eyebrows  Legs  Back  Feet/Toes  Beard  Neck: Front/Back  Chest  Lip  Hands/Finger  Nose  Bikini Line*

| | | |
|---|---|---|
| Accutane | No | Yes |
| Heart Condition | *No* | *Yes* |
| Acne | No | Yes |
| Hemophilia | No | Yes |
| Canker Sores | No | Yes |
| Hepatitis | No | Yes |
| Cancer | No | Yes |
| High Blood Pressure | No | Yes |
| Metal Pins in Body | No | Yes |
| Diabetes | No | Yes |
| Moles | No | Yes |
| Genital Herpes No | No | Yes |
| Pacemaker | No | Yes |
| Latex Allergies No | No | Yes |
| Psoriasis | No | Yes |
| Hearing Aid | No | Yes |
| Cold Sores | No | Yes |
| Keloid Scars | No | Yes |
| Contact Lens | No | Yes |
| Tuberculosis | No | Yes |
| Lupus | No | Yes |
| Epilepsy | No | Yes |
| Roscea | No | Yes |
| Fainting | No | Yes |
| Bruising | No | Yes |
| Auto Immune | No | Yes |
| Psychiatric | No | Yes |
| Cosmetic Surgery | No | Yes |
| Neuro-Muscular | No | Yes |
| Anxiety | No | Yes |

**Evaluation of Skin/Hair** *circle which applies*

*Previous treatments:*  *Electrology*  *Laser*

**Temporary Methods** Shaving  Tweezing
Depilatories  Waxing

**Existing Skin Condition**: Scarring  Acne
Pigmentation  Telanglectasia  Rash
Other____________

**General Skin Condition**_______________

**List current facial products**_____________

**Preliminary Protocol for Laser** circle which applies

**How do you tan**? Good  Fairly Good  Not good
**How do you heal?** Very good  Fairly Good  **Slow**

******Taking any type of drugs** ***Antibiotics***
Prescription Medications  **Photosensitve Meds**
Glycolic  Retina
**Allergic to any Medications**  No  Yes
What_____________________________

**LIST ALL MEDICATIONS (INCLUDING OTC and VITAMINS)**

____________________________________

____________________________________

**Female Client** circle which applies

In Menopause  Post menopause  PCOS  Pregnant/Nursing
Birth Control Pills  Hormone Pills  Endocrine Problems  Hysterectomy

---

I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated are as stated on this private record.  I understand that repeated treatments are necessary for permanent results.

Client signature_______________________________________Date_______________

Medical Director signature________________________________Date______________