IMAGE PERFECT LASER

Laser Hair Removal

PATIENT INFORMATION

Date:

Name:

Address:

City: State: Zip:

Home Phone: Business phone:

Cell Phone: Email Address:

Date of Birth: Sex:

How did you hear about Image Perfect Laser?

PERSONAL HISTORY: If yes to any of the following, please explain

Waxing	Y	N	When__________________________ What areas_____________________
Electrolysis	Y	N	When___________________________ What areas_____________________
Cold Sores (Herpes Simplex)	Y	N	________________________________
Sensitive to bleaching agents	Y	N	________________________________
Hormonal Imbalance	Y	N	_________________________________
Skin Infections	Y	N	_________________________________
Used Accutane in the last 6 weeks	Y	N	_________________________________
Tanned within the last 6 weeks	Y	N	_________________________________
Laser skin resurfacing	Y	N	_________________________________
Chemical Peels	Y	N	__________________________________
Microdermabrasion	Y	N	__________________________________

Are you being treated for a medical illness? If yes, explain ________________________

List any medications that you are taking_______________________________________

What area (or areas) are you considering for Laser Hair Removal? _______________

Would you like to receive information on other cosmetic procedures? Y N