DIVINE TOUCH THERAPY

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LASER HAIR TREATEMENT

Medical History Form

Name: ________________________________Phone Number: ______________________________

Date: _________________________________Email Address: _______________________________

Age: __________________________________Gender: ____________________________________

What is your hereditary/Ethnic background? ____

Are you pregnant, or lactating? Yes ___No____

Do you have permanent make up or tattoos? Yes ____No____

Do you currently use or receive depilatories or waxing? Yes____ No____

Are you currently applying any topical medications? Yes ___ No____ If so please explain:

____

Are you, or have you used Accutane? Yes ____No ____

If yes, how long have you stopped using it? ____

Have you had a chemical peel, laser, or other medical skin care treatments previously? Yes ____No___

If so, what and when was your last treatment? ____

Do you have regular Collagen, Botox, or other filler injections? Yes ____No____

Have you had any other invasive cosmetic surgeries, or procedures? Yes ____No____

if yes, when? ____

Do you participate in vigorous activity, or sports? Yes ____No____

Do you smoke? Yes ____No____

Do you develop cold sores or blisters? Yes ____No____

Do you have any Allergies? Yes ____No____

Are you currently taking any other medications? Yes ____No____

If so, please explain: ____

Do you currently have a sunburn or windburn? Yes___ No____

Do you regularly sun tan or regularly go to tanning booth? Yes____ No____

If so, were you exposed within last 14 days? Yes ____ No_____

When exposed to the sun for 1 hr without sunscreen do you: (pick one)

Always burn and never tan_______

Always burn, sometimes tan______

Sometimes burn, sometimes tan_____

Always tan, never burn______

Do you have a history of Hormonal or endocrine disorders? Yes____ No____

If so, please explain____

Do you consider your skin: (pick one)?

Sensitive_____

Resilient_____

unsure______

For Skin Care Treatments:

Describe any concerns you have with your skin, or goals you`d like to achieve with your skin:
____
____

____
____

What is your skin care regimen or routine?

1.____

2.____

Client Signature______________________________ Date____________________________