

Light Touch Laser

Laser Hair Removal
& Botox®

Laser Hair Removal Screening Form

This data is collected to ensure the best treatment possible. It is confidential and is used solely to assess your candidacy for laser treatment at Light Touch Laser.

Name: _____

Date: _____

Age: _____

Phone # 1: _____

Phone # 2: _____

Address: _____

E-Mail: _____

1. Check all areas you would like treatment then circle your primary concern:

| | | |
|------------|------------|-------------|
| Upper lip | Underarms | Bikini Area |
| Chin | Arms | Chest |
| Sideburns | Hands/Feet | Abdomen |
| Cheeks | Thighs | Back |
| Neck Front | Lower Legs | Buttock |
| Neck Back | Full Legs | _____ |

2. Check all methods of hair removal you have used in the past, then circle any methods are you currently using.

| | |
|----------------------|----------|
| Professional Waxing | Tweezing |
| Home Waxing | Shaving |
| Creams (Nair®/Neet®) | Sugaring |
| Threading | Laser |
| Electrolysis | IPL |
| Epilady™ | _____ |

When was your last treatment? _____

3. How often do you have to remove your hair to maintain it?

| | |
|-------------|--------------------|
| Twice daily | 2-3 Times per week |
| Daily | Weekly |

4. In the last year, have you seen an increase in the amount of hair growth in the area you'd like treated ?

No Mild Moderate Substantial Unsure

5. What colour is your hair in the area to be treated? Check all that apply.

Black Brown Blond Grey Light Brown
Light Blond White Red

6. Check any process that you have had, then circle any received within the last month.

Chemical peel Tanning Bed
IPL Laser Resurfacing
Microdermabrasion

7. Has your skin ever had a negative reaction to a treatment, product or substance? Explain. _____

8. Do you have scars in the area to be treated?

Yes No

Do you form keloids (raised welted scar tissue) when you scar?

Yes No I don't know

9. Do you have any tan present in the treatment area at this time?

Yes No Unsure

10. When was the last time you had sun exposure that resulted in any change in the colour of your skin? _____

11. List any known allergies:

Radio _____ Print _____
Yellowpages _____ Friend _____
Website _____ Other _____

12. List any medications/ herbal supplements/ topical creams you use, then circle any of these that are known to cause light sensitivities. _____

Specifically, have you taken Accutane in the last six months? Yes No

13. Please describe any current skin infections: _____

14. Do you ever get coldsores? Yes No
When was your last outbreak? _____

15. Have you ever had genital herpes?
Yes No
When was your last outbreak? _____

16. Have you tested positive for HIV ?
Yes No

17. What is your skin type in the area you are considering to have laser hair removal?

- Type I- Always burn, never tan (extremely fair skin/blond hair/blue/green eyes)
- Type II- Usually burn, tan less than about average (fair skin, sandy brown to brown hair, green/blue eyes)
- Type III- Sometimes mild burn, tan about average (medium skin, brown hair, green/brown eyes)
- Type IV- Rarely burn, tan more than average (olive skin, brown/black hair, dark brown/black eyes)
- Type V- Moderately pigmented, tans profusely (dark brown skin, black hair, black eyes)
- Type VI- Deeply pigmented, never burns (black skin, black hair, black eyes)

How did you hear about us?

This section applies to women only-

Is your period:

Regular _____ Irregular _____
Menopause _____ Hysterectomy _____
Ceased due to birth control method _____

Are you possibly pregnant?

Yes No

Have you had children?

Yes No

Have you ever had your testosterone levels checked or been tested for a hormonal problem?

Yes No

Have you been diagnosed with any of the following conditions?:

Polycystic Ovarian Syndrome (PCO)
Thyroid Disorder
Hirsutism

Are you on, or have you ever undergone Hormone Replacement Therapy?

Yes No

**Thank you for
considering
Light Touch Laser
for your hair
removal needs!**