



10215 SW Hall Blvd. | Suite 200
Tigard, Oregon 97223

CLIENT QUESTIONNAIRE

PATIENT NAME _____

DATE _____

Please answer the following:

Do you have, or have you ever had (circle Y or N):

| | | | | | |
|----------------------|---|---|------------------------|---|---|
| High blood pressure | Y | N | Hepatitis | Y | N |
| Ulcers | Y | N | Blood Transfusion | Y | N |
| Heart attack | Y | N | Artificial heart valve | Y | N |
| Irregular heart beat | Y | N | Abnormal healing | Y | N |
| Seizure disorder | Y | N | Herpes/cold sores | Y | N |

Please explain: _____

Do you or any of your blood relatives have a history of (circle one or both):

| | | | | | |
|-----------|----|----------|-------------------|----|----------|
| Diabetes | me | relative | Melanoma | me | relative |
| Lupus | me | relative | Other skin cancer | me | relative |
| Eczema | me | relative | Psoriasis | me | relative |
| Asthma | me | relative | Bleeding disorder | me | relative |
| Hay-fever | me | relative | Non-skin cancer | me | relative |

Please explain: _____

Do you currently have any health problems in the following areas?

| | | | |
|--------------------------|----------------|----------------------|----------------|
| Blood/Circulatory system | Kidneys | Anxiety/depression | Joint problems |
| Lymph nodes | Nervous system | Digestive system | Liver |
| Fevers | Allergies | Persistent headaches | Lungs |
| Ears/nose | Eyes | | Thyroid gland |
| Bowels/bladder | Muscles/bones | | |

Please explain: _____

Please list all current medications (including over-the-counter, vitamins, herbs, etc):

Please answer the following yes/no questions:

Y N

_____ _____ Do you smoke?

_____ _____ Are you allergic to any medications, topical products, or adhesives?

if so, please list here: _____

| | | |
|-------|-------|---|
| Y | N | |
| _____ | _____ | Do you use a tanning bed? |
| _____ | _____ | Do you use sunscreen? |
| _____ | _____ | Do you have a history of blistering sunburns? |

Lifetime skin exposure (circle one): HIGH MODERATE LOW

The following pertains to patients wishing to have any LASER treatments:

If a question does not pertain to you, please leave blank

| | | |
|-------|-------|--|
| Y | N | |
| _____ | _____ | 1) Is the hair you want removed either black or brown? <i>If no, hair laser will not work for your hair.</i> |
| _____ | _____ | 2) Have you tanned your skin in any way in the last 6 weeks including self-tanners? <i>Please stop using any sun tanning beds and self-tanners 4 weeks prior and throughout this hair removal process.</i> |
| _____ | _____ | 3) Do you pluck, wax, or bleach the hair you want removed? <i>Please stop doing this 2 weeks prior to laser in order to achieve a more effective treatment.</i> |
| _____ | _____ | 4) Do you have pigmented (brown) patches in the areas where you want to use the hair laser? Or do you usually develop pigmentation after an injury? <i>If so, you will need to use a skin bleacher prior to the procedure and will need a consultation prior to treatment.</i> |
| _____ | _____ | 5) Area you taking any medications that make you more sensitive to the sun? <i>(ie: Accutane, tetracycline, doxycycline, thiazide diuretics, St. John's wort)</i> |
| _____ | _____ | 6) Do you have a history of herpes (cold sores) in the area to be treated? <i>If so, you need to obtain a prescription for Valtrex to begin prior to laser treatment from your primary provider. (includes bikini area)</i> |
| _____ | _____ | 7) Are you/or do you plan to become pregnant during the treatment? <i>Hair laser is not recommended during pregnancy since hair may increase during this time.</i> |
| _____ | _____ | 8) Do you have a pacemaker? <i>If so, laser treatment is not recommended.</i> |