Laser Lounge Med Spa
3613 Williams Dr. ste 1005 Georgetown, TX 78628 512-863-2118

Client Information

Name ____ Date _______________

Name of Guardian if under 18 years old ____

Date of Birth ______________ Age ________ Occupation _______________________

Home Address ____________________________________ State _____ Zip _________

Preferred contact phone # ____

Is it ok to leave a message on this phone or with the person who answers it, if it is not yourself? ______ Yes ______ No

To receive appointment reminders and our monthly newsletter please provide your email ____

If you would like to receive reminders by text please provide your cell phone # and your cell phone provider ____

Emergency Contact Name and Phone ____

Who can we thank for referring you? ____

Which of the following best describes your skin type? (Please circle one)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

Medical History

Are you currently under the care of a physician? Yes No

Are you currently under the care of a dermatologist? Yes No

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Do you have any of the following medical conditions? (Circle all that apply)

Cancer	Diabetes	High Blood Pressure	Herpes
Arthritis	Frequent cold sores	HIV/AIDS	Keloid scarring
Skin disease	Seizure disorder	Hepatitis	Hormone Imbalance
Thyroid imbalance	Blood clotting abnormalities		Any active infection

Do you have any other health problems or medical conditions? If yes, please list
____

What oral medications are you presently taking? (Circle all that apply)

Accutane Hormones Antibiotics Steroids

Other ____

Have you ever used Accutane? Yes No If yes, when did you last use it? ______________

What topical medications and/or creams are you currently using? (circle all that apply)

Retin-A Renova Others ____

Have you ever had laser hair removal ? Yes No

Have you used any of the following hair removal methods in the last 6 weeks?

Shaving	Waxing	Electrolysis	Plucking
Tweezing	Stringing	Depilatories	

Have you had any recent tanning or sun exposure that changed the color of your skin?
Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have hyper-pigmentation (darkening of the skin) or hypo-pigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes, please describe ____

Do you have any food, drug or cosmetic allergies? Yes No

If yes, please list ALL ____

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For Female Clients

Are you pregnant or trying to become pregnant? Yes No

Are you on oral birth control pills? Yes No

Are you breast feeding? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that is my responsibility to inform the technician, esthetician, therapist or doctor of my current medical or health conditions and to update this history as current medical history is essential for the caregiver to execute appropriate treatment procedures. I understand if I fail to provide any changes to my medical profile my caregiver that no liability will fall on my caregiver.

____

Patient Signature Date