Laser528
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Name: _____
Address: _____
_____
City: _____ State: _____ Zip Code: _____
Birthdate: _____
Phone: (Main) _____ (Message) _____
Email: _____
How did you hear about us? _____

Please answer the following questions:

1. Do you have ANY current chronic medical illnesses?
   Y / N
   Please list: _____
2. Are you currently under a doctor's care?
   Y / N
   Please list: _____
3. Are you currently taking ANY medication, herbal supplements or use topical cream and/or ointment(s) on a regular basis?
   Y / N
   Please list: _____
4. Do you have allergies to ANY food or substances?
   Y / N
   Please list: _____
5. Are your menstrual periods regular?
   Y / N
6. Are you or could you be pregnant?
   Y / N
7. Do you have ANY history of herpes simplex (e.g. cold sores, fever blisters or genital)?
   Y / N
8. Do you have a history of keloid scarring?
   Y / N
9. Have you taken Accutane or anticoagulants in the last 6 months?
   Y / N
10. Do you have ANY permanent make-up, injectables, implants or tattoos or surgical areas?
    Y / N
    Please list: _____
11. Have you been in the sun, tanning bed or used sunless tanning cream within the last 4 weeks?
    Y / N
12. Which area(s) would you like treated? _____
    _____

Signature: _____
Date: _____