Health History Assessment

Name: _____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth/Age: _____Email Address: _____

Home Phone: _____ Business Phone: _____

Occupation/Profession: _____

Referred by: G Phone Book G Newspaper G Carolina Women G Web G Person G Symphony Directory G Radio G Other

Check the areas you wish to have treated:

Facial/Head Areas

☐ *Lip (upper) ☐ *Neck ☐ Eyebrows
☐ *Lip (lower) ☐ *Sideburns ☐ Nasal Bridge
☐ *Chin ☐ *Cheeks ☐ Other
☐ *Ears ☐ Hairline

Body Areas

☐ *Sternum ☐ Swimsuit Line ☐ Fingers/Toes
☐ *Breast ☐ Thighs ☐ Other
☐ *Abdomen ☐ Legs
☐ *Arms ☐ Underarms

If hair growth in females in above areas noted with asterick (*****), explain if onset was sudden or gradual and over what period of time: _____

Family members with similar hair growth patterns: _____

Previous electrolysis or laser treatments: _____ With whom: _____

Date of first treatment: _____ Date of last treatment: _____

Modality if known: _____

Areas treated and treatment schedule of each area: _____

Aftercare used: _____ Skin reactions/healing: _____

Was previous treatment successful? _____ Reason for discontinuing treatment: _____

Temporary hair removal methods previously or currently used:

Methods	Areas	Frequency	Last Used
Tweezing/E. Tweezer/Waxing			
Depilatory/Shaving			
Cutting			
Bleaching			
Other			

Check, if in the past, you have had any signs on your skin:
☐ Swelling ☐ Itching ☐ Dryness ☐ Oiliness ☐ Pigment Changes

Check if you have had any of the following lesions on your skin:
☐ Acne ☐ Eczema ☐ Dermatitis ☐ Psoriasis ☐ Petechiae (red point) ☐ Lipomas (soft lump) ☐ Keloids ☐ Scars
☐ Cancer ☐ Boils ☐ Blisters ☐ Hives ☐ Bites ☐ Warts ☐ Moles ☐ Rashes

Check if you have had allergies to:
☐ Medicines ☐ Cosmetics ☐ Plants ☐ Benzocaine ☐ Metals ☐ Petrolatem
☐ Soaps ☐ Foods ☐ Sun ☐ Aloe ☐ Other

Ever had problems with your skin healing: _____ Explain: _____
Use facial scrubs or abrasive sponges: _____ Areas/frequency: _____
Ever use Retin A: _____ Dates/explain: _____

Ever use artificial tanning: _____ Areas/frequency: _____

Check the following, if you have ever had, or have been treated for the following conditions:

☐ Bleeding Problems/Hemophilia*	☐ High Blood Pressure	☐ Diabetes	☐ Herpes (location) _____
☐ Circulatory Problem	☐ Heart Disease	☐ Cancer	☐ Sexually Transmitted Diseases
☐ Breathing Problems	☐G HIV Blood Test	☐ Chemo/Radiation	☐ Hepatitis (Type) _____
☐ Pacemaker*	☐ Epilepsy	☐ Tuberculosis	☐ Other

Comments on above if checked: _____

_____

Currently being treated by a physician or other healthcare provider: _____ Explain: _____

Current medications (oral, injection, topical – Rx & non-Rx): _____

_____

Past medications (oral, injection, topical – Rx & non-Rx): _____

_____

Do you have temp./perm. implants (i.e. IUD, dental, orthopedic): _____ Do you wear contacts: _____

Is your stress level average or high: _____

Frequency of gyn. examinations: _____ Date of last exam: _____

Are you presently pregnant or are attempting to become pregnant: _____ Have menstrual cycle every_____days

If post-menopausal, give date of last menses: _____ Was menstrual cycle regular: _____ Increase/decrease of hair: _____

Hysterectomy: _____ Date: _____ Ovaries removed: _____ Increase/decrease of hair: _____

Estrogen/progesterone therapy: _____ Dates/explain: _____ Increase/decrease of hair: _____

Ever taken birth control pills: _____ Dates/explain: _____ Increase/decrease of hair: _____

Ever had an ovarian cyst or cystic ovaries: _____ Date/explain: _____

Is thyroid function normal: _____ Explain: _____

Changes in weight or voice: _____ Explain: _____

Ever inform your physician/gyn. of your hair growth: _____ Response: _____

Ever had a hormone test: _____ Date/results: _____

I understand health history information is important to the electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given to me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes.

I understand a series of treatments is necessary to achieve permanent hair removal based on my previous temporary methods of hair removal, the science of electrology, and my individual physiological factors.

I have been advised of the post–treatment healing process, the possible risks related to treatment and agree to follow all aftercare instructions, and to notify the electrologist of any difficulty in healing.

I understand that photographs taken prior to treatment and during the process of my treatments will aid in providing feedback on the treatment plan. I understand these photographs are for private educational use and will be used accordingly.

_____

Client's Signature Parent's/Guardian's Signature of Minor Date

I acknowledge the following tissue alterations in areas to be treated: _____

_____

_____

Client's Signature Parent's/Guardian's Signature of Minor Date

GentleLASE Treatment Record

Date: ________________________

Patient's Name: ____ Dr.: _________________________________

Area Treated	Spot Size	Energy	# Pulses	DCD	Spray	Delay