MEDICAL EVALUATION FOR LASER HAIR REMOVAL

History:

Patient name_____ D.O.B._____ Date_____

PT concern(s):_____

PMHx:_____

PSHx:_____

Medications:_____

Photosensitizing medications □Yes □No Topical retinoids □Yes □No

Current blood thinner use □Yes □No Current antibiotics use □Yes □No

Allergies:_____

Review of the following questions:

□ Are you pregnant or trying to get pregnant?
□ Are you breast feeding?
□ Do you bruise easily?
□ Do you have any skin disease?
□ Do you have skin cancer?
□ Have you ever had melanoma?
□ Do you have a history of cold sores?
□ Do you have a history of severe scarring (keloid) or pigmentation?
□ Recent facial surgery (within 6 months)?
□ Sun exposure in area to be treated in last 2 – 4 weeks?
□ Dissatisfaction with results of cosmetic or laser surgery in the past? _____

_____

□ **Client history form was reviewed**

Do you have any of the following:

□ Parkinson's Disease	□ Eye Disease	□ Double Vision	□ Droopy Eyelids
□ Glaucoma	□ Hepatitis	□ HIV	□ Cancer
□ Vision Problems	□ Muscle Weakness	□ Multiple Sclerosis	□ Melanoma
□ Autoimmune Disease	□ Lambert-Eaton Syndrome	□ Myasthenia Gravis	□ Lou Gherig/ ALS

Physical Examination:

Fitzpatrick Skin Type (From Assessment Form) (Circle) I II III IV V VI

Treatment PLAN □ Approved for Laser Hair Removal

MD/NP/PA_____ **Date:** _____

2021.05